S T A T E O F I L L I N O I S

DEPARTMENT OF PUBLIC AID

MEDICAL ASSISTANCE PROGRAM

H A N D B O O K

F O R

P H Y S I C I A N S

DEFINITIONS

Department of Human Services - The governmental agency which determines whether an individual is eligible for public assistance, whether financial assistance or medical assistance. When medical assistance is approved, the client receives coverage through the Department of Public Aid.

Department of Public Aid - The governmental agency which oversees the Medical Assistance program to provide medical assistance to clients determined eligible for it by the Department of Human Services. The Medical Assistance program of the Department of Public Aid determines which services are covered services, processes claims from medical provider, and approves payment to medical providers for services rendered.

Document Control Number (DCN) - A unique number assigned by the Department to identify each claim that is submitted by a provider.

Fee-for-Service - A payment methodology for certain services provided by physicians in hospital outpatient and office settings.

Form DPA 2360 - The Department of Public Aid Health Insurance Claim Form.

HCPCS - HCFA (Health Care Finance Administration) Common Procedure Coding System.

MediPlan Card - A card issued by the Department of Human Services which contains information about the client's eligibility under the Medical Assistance program.

Prior Approval - Some services require a prior approval review before the service may be rendered. The prior approval process is presented in detail in Appendix A-6.

Procedure Code - The appropriate codes from the Current Procedural Terminology or appropriate HCPCS codes unless otherwise specified by the Department, and subject to the limitation described elsewhere in this Handbook. "Otherwise Specified" can include, for example, a Department generated code described in a Provider Bulletin.

Provider Participation Unit - The Unit in the Department which is responsible for determining provider eligibility prior to approving and issuing a provider number to allow participation in the Medical Assistance program.

Recipient Identification Number (RIN) - The nine digit identification number unique to the individual receiving public assistance. It is vital that this number be correctly entered on billings for services rendered.

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SECTION II

CHAPTER A-200

Physician Services

A-200 BASIC PROVISIONS

For consideration of payment by the Department for physician services, such services must be provided by a physician enrolled for participation in the Illinois Medical Assistance Program. Services provided must be in full compliance with both the general provisions in Chapter 100 and the policy and procedures contained in this handbook. Exclusions and limitations are identified in specific topics contained herein.

A-201 PHYSICIAN PARTICIPATION

A Doctor of Medicine (M.D.) or Osteopathy (D.O.) who holds a valid Illinois (or State of Licensure) license to practice medicine in all its branches, is eligible to be considered for enrollment to participate in the Medical Assistance Program.

- Residents generally are excluded from participation as the cost of their services is included in the hospital's reimbursable costs. If, by terms of their contract with the hospital, they are permitted to and do bill private patients for their services, participation may be approved.

- Hospital-based physicians who are salaried, with the cost of their services included in the hospital reimbursement costs, are not approved for participation unless their contractual arrangement with the hospital enables them to make their own charges for professional services and they do bill private patients and collect and retain payments made.

- Physicians holding non-teaching administrative or staff positions in hospitals and/or medical schools may be approved for participation in the provision of direct patient services if they maintain a private practice and bill private patients and collect and retain payments made.

- Teaching physicians who provide direct patient care may be approved for participation provided that salaries paid by hospitals or other institutions do not include a component for treatment services.

A physician requesting to participate in the Illinois Medical Assistance Program must also meet the following criteria:

1) Be licensed to practice medicine in all its branches. Out of State Physicians shall have unrestricted licenses to practice medicine and surgery in the state in which they practice. Consultants shall be board qualified or board certified in their specialty.

2) Be prepared to provide, if requested by the Department, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business, enterprises, joint ventures, agencies, institutions or other legal entities providing any form of health care services to Public Aid recipients.

3) If providing maternity care, have hospital delivery privileges or have a written agreement with a physician who has such privileges.

The provider must agree to:

- verify eligibility prior to providing services.
- allow clients the choice of accepting or rejecting medical or surgical care or treatment.
- provide supplies and services in full compliance with all applicable provisions of State and federal laws and regulations pertaining to nondiscrimination.
- hold confidential and use for authorized program purposes only, all Medical Assistance information regarding recipients.
- furnish to the Department, in the form and manner requested by it, any information it requests regarding payments for providing goods or services or in connection with the rendering of goods or services or supplies to recipients.
- make charges for the provision of services and supplies to recipients in amounts not to exceed the provider's usual and customary charges.
- accept as payment in full the amounts established by the Department.
- accept assignment of Medicare benefits for Public Aid recipients eligible for Medicare, when payment for services to such persons is sought from the Department.

It is required that each physician **must** enroll with the Department in order to be considered for participation.

PROCEDURE: The physician must complete and submit:

• Form DPA 2243	Provider Enrollment/Application Form
• Form DPA 1413	Agreement for Participation
• Form DPA 2307	Hospital, Professional School or Group Practice as Alternate Payee (if applicable)
• Form DPA 2306	Power of Attorney (if applicable)
• Form DPA 1517/1517A	Provider Forms Request

These forms may be obtained from:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (printed in ink or typewritten), signed and dated in ink by the physician, and returned to the above address. The physician should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the physician requests a specific enrollment date.

= An Alternate Payee, Form DPA 2307, may be designated to address the physician's circumstances, which must meet one of the following conditions:

- The physician has a contractual or salary arrangement, as a condition of employment with a hospital or professional school.

= C The medical practitioner is part of a practitioner-owned group practice consisting of three or more full-time licensed practitioners or the equivalent thereof.

C The physician is employed by a practitioner who requires, as a condition of employment, that the fees be remitted to the employer.

A-201.1 PARTICIPATION APPROVAL

When participation is approved, the physician will receive a computer-generated notification, the Provider Information Sheet, listing all data carried on Department computer files. The physician is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix A-7. If all information is correct, the physician is to retain the Provider Information Sheet for subsequent use in completing billing statements to ensure that all identifying information required is an exact match to that in the Department file. If incorrect, refer to Topic A-201.31.

A-201.2 PARTICIPATION DENIAL

Written notification to a physician of denial of an application for participation will include the reason for the denial.

Within 10 days after such notice, the physician may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within 10 days, or is received but later withdrawn, the Department's decision shall be a final and binding administrative determination. (See Section III, General Appendix 7A, Rules For Department Actions Against Medical Vendors and General Appendix 7B, Rules For Practice For Medical Vendor Administrative Proceeding.)

A-201.3 PROVIDER FILE MAINTENANCE

The information carried in Department files for participating physicians must be maintained on a current basis. The physician and the Department share responsibility for keeping the file updated.

A-201.31 Physician Responsibility

The information contained on the Provider Information Sheet is that carried on Department files. Each time the physician receives a Provider Information Sheet, it is to be reviewed carefully for accuracy.

Inasmuch as the Provider Information Sheet contains information to be used by the physician in the preparation of billing statements, any discrepancies are to be corrected and returned to the department for correction within 30 days of the change.

A-201 **PHYSICIAN PARTICIPATION** (Continued)

A-201.3 **PROVIDER FILE MAINTENANCE** (Continued)

A-201.31 **Physician Responsibility** (Continued)

PROCEDURE: The physician is to line out the incorrect data, enter the correction, and sign the Provider Information Sheet on the line provided with an original signature. The Provider Information Sheet, with appropriate corrections, is to be sent to the address below or to the address on the reverse side of the Provider Information Sheet:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Any time a physician effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified in the same manner as indicated in the preceding paragraph. When possible, notification should be made in advance of a change.

Failure of a physician to properly notify the Department of any corrections and/or changes, including the effective date of such changes, may cause an interruption in participation and payments. Refer to General Appendix 7A and 7B.

Confirmation of the requested change will be sent to the physician in the form of an updated Provider Information Sheet. Upon receipt of the corrected Provider Information Sheet, invoices may be submitted.

A-201.32 **Department Responsibility**

Whenever there is a change in a physician's enrollment status, an updated Provider Information Sheet will be generated indicating the change and the effective date.

A-201.4 **BILLING FORM DISTRIBUTION**

The Illinois Department of Public Aid (IDPA) will distribute billing invoices and envelopes only upon written request or receipt of form DPA 1517/1517A (Provider Forms Request) which is included with the enrollment application and with each supply of forms delivered. Physicians in Cook, DuPage, Kane, Kankakee, Lake, Winnebago, and Will counties must use the DPA 1517A. Physicians in all other counties are to use DPA 1517.

IDPA FORM NUMBERS are to be listed exactly as they appear in Appendix A-8 of this handbook. When ordering the forms and envelopes, request the specific number needed of each item for a three month period. Allow 30 days for delivery.

A-202 PHYSICIAN REIMBURSEMENT

A-202.1 CHARGES

Physicians are to make charges to the Department only after services have been provided. Charges are to be the physician's usual and customary charges to non-Public Aid patients for the services provided.

= Except as otherwise noted in this handbook, e.g., Topic A-210.4, a physician may charge only for services personally provided, or which are provided under direct supervision in the physician's offices by licensed or certified staff, e.g., laboratory tests done by a technician in the physician's employ.

A physician may not charge for services provided by another physician even though one may be in the employ of the other. The treating physician, if it is a condition of employment, may elect to have payment directed to the employing physician under the alternate payee option allowed in the provider enrollment process.

= **EXCEPTION**: A physician is allowed to bill for a service provided by another physician when the second physician is "substituting" for the attending physician. This provision is to cover situations where the attending physician is ill, on vacation, or because of an emergency situation. The substitute physician does not have to be enrolled in the Medical Assistance Program, but is required to be a licensed physician as defined in Topic A-201. In addition, the substitute physician may not be terminated, suspended, barred or otherwise excluded from participation or have voluntarily withdrawn from the program as part of a settlement agreement. The time limitations are 14 days for a single incident and up to a maximum of 90 days per year for the attending physician. If the substitute period extends beyond the 14 days per single incident, the physician must enroll with the Department.

PROCEDURE: The attending physician should bill the Department in the usual manner and show the name and the provider number plus "S" of the substitute physician in field 19 (referring Physician Number) of Form DPA 2360, Health Insurance Claim Form. **The attending physician retains the responsibility for any quality of care issues. For Department audit purposes, it would be advisable for the physician to maintain on file a copy of an agreement between him/her and the substituting physician.**

If a physician provides any services in a hospital setting, he/she may charge for the services only if he/she is not reimbursed by the hospital and the hospital does not include the cost of the physician's services in the hospital's reimbursable cost statement. It is the responsibility of the physician, if charges are made for such services, to verify that the services provided are not included as a part of the contract with the hospital.

To be paid for services, all claims, including claims that are rebilled, MUST BE RECEIVED WITHIN ONE (1) YEAR OF THE DATE OF SERVICE.

A physician may not charge for services provided outside the physician's office by anyone other than the physician.

A-202 **PHYSICIAN REIMBURSEMENT** (Continued)

A-202.1 **CHARGES** (Continued)

= **Exception:** A physician may submit a bill for services provided by an Advanced Practice Nurse (APN) or a Physician Assistant (PA), in any setting, as long as such practice is not in conflict with the:

- Nursing and Advanced Practice Act (225 ILCS 65)
- Physician Assistant Practice Act (225 ILCS 95)
- Department of Professional Regulations rules for administration of Physician Assistant Practice Act (68 Ill.Adm.Code1350)
- Department of Professional Regulations rules for administration of Nursing and Advanced Practice Nurses Act (68 Ill.Adm.Code1305)

A-202.11 **Allowable Charges By Teaching Physicians**

Teaching physicians who provide direct patient care may submit charges for the services provided, if the salary paid them by the hospital or other institution does not include a component for treatment services. Charges for concurrent care for the benefit of teaching are not reimbursable and are not to be submitted for payment.

Charges are to be submitted only when the teaching physician seeking reimbursement has been personally involved in the services being provided. In the case of surgery, this means presence in the operating room, performing or supervising the major phases of the operation taking personal responsibility for the services provided, and personally performing services considered necessary to confirm the diagnosis and findings. For nonsurgical patients being seen in a hospital or in other medical settings, charges are to be submitted only if the teaching physician is personally responsible for all services provided and is personally involved by having direct contact with the patient.

The patient's medical record must show that these requirements have been met. All such entries must be signed and dated by the physician seeking reimbursement. A signature may be actual or electronic. Signature stamps are not acceptable.

A-202.12 **Services Provided By Hospital-Based Physicians/Salaried**

Reimbursement for services provided by a salaried hospital-based physician to a client is included in the hospital's reimbursement rate. There is no separate payment to the hospital for the physician's services, and no charges should be submitted to the Department by the hospital or the physician with one exception. When services are provided by a salaried physician and those services are provided in the Emergency Department, hospitals may bill for the services provided by one salaried Emergency Department physician on Form DPA 2360, Health Insurance Claim Form, in addition to the Ambulatory Procedure Listing (APL) billed on the UB-92. If more than one salaried physician provides services to the same patient, the services provided by additional salaried physicians are considered part of the all-inclusive rate and cannot be billed as fee-for-service.

If the hospital provides a non-emergency/screening service, the hospital has the option of billing for the screening sevices on the UB-92 or the DPA 2360, but not both.

A-202.1 **CHARGES** (Continued)

A-202.13 **Services Provided By Interns And Residents**

When an intern or a resident provides medical services to a Public Aid patient, the Department will allow reimbursement for the services, but only to the teaching physician. The teaching physician must: 1) be personally involved in the patient's care; and 2) directly supervise the intern's or resident's activities. The employing hospital and/or teaching physician must maintain verification, which is readily available to Department staff, that these requirements have been met. Such entries must be signed and dated by the physician seeking reimbursement.

= **EXCEPTION:** For residents beyond their first year, the Department will recognize the medical school's or sponsoring hospital's protocols in the Department's audit process if the protocol of each residency program meets all of the following: 1) identifies the level of supervision for each year of residency; 2) describes specific situations where residents may and may not function independently; and 3) specifies the manner in which documentation will be maintained to verify that the teaching physician has personally supervised the resident to the degree required in the protocol and has participated in the patient's care to the degree required in the protocol. The Department will accept the medical school's or sponsoring hospital's residency program supervision protocol and other medical record documentation in the determination of whether the teaching physician has provided appropriate supervision and assumed appropriate responsibility for the services provided by the resident. If the protocol and residency records are not readily available in the event of a Department audit, the medical school or sponsoring hospital will be held to the requirements specified in the first paragraph of this topic.

A-202.14 **Unusual Travel**

Charges may be submitted to the Department for travel by a physician if the physician personally accompanies a recipient who is being transported, e.g., by ambulance or air from one hospital to another.

PROCEDURE: Charges are submitted on Form DPA 2360, Health Insurance Claim Form, using procedure code 99082. The physician is to provide documentation regarding 1) the medical necessity for his/her personal attendance; 2) the amount of time required; and 3) the distance traveled one way.

A-202.2 ELECTRONIC CLAIMS PROCESSING

= Physicians may submit claims electronically, using the current version of the National Standard Format (NSF), which may be obtained from the website at http://www.hcfa.gov/medicare/edi/edi5.htm. Medicaid claims can be submitted electronically via the Recipient Eligibility Verification (REV) system using one of the participating REV vendors. The companies participating in the REV program are listed in the Department's website at http://www.state.il.us/dpa/html/medical rev.htm. Physicians should contact each of the companies listed to obtain further information regarding submission of electronic claims.

A-202.3 INVOICE PREPARATION AND SUBMITTAL

See Chapter 100, Topic 141 for policy and procedure regarding bill submittal. For information on billing for services provided and submittal of claims for clients eligible for Medicare Part B, see Chapter 100, Topic 122.14.

A-202.31 Completion of DPA 2360

A copy of Form DPA 2360, Health Insurance Claim Form, and detailed instructions for completion are included in Appendix A-1.

Procedure Codes: Enter the appropriate codes from the Current Procedural Terminology (CPT) or appropriate HCPCS codes, unless a Department generated code has been specified in this Handbook, Provider Bulletin or by an Official Publication.

Type of Service Codes: To collect data and make appropriate payment, it is required that the claim include the type of services provided. Type of Service (TOS) codes may be found on the reverse side of the claim form. These codes are also listed in Appendix A-1 of this handbook.

Place of Service Codes: It is required that the claim include the place where the services were provided. Place of Service (POS) codes are listed in Appendix A-1 of this handbook and on the reverse side of the claim form.

Diagnosis Codes: In addition to the Procedure Code, all claims require a primary diagnosis code as listed in the International Classification of Disease, Ninth Revision, Clinical Modification (ICD-9-CM). Physicians are also encouraged to identify and code the secondary diagnosis.

A-202.32 Medicare Part B Eligible

Physicians in Illinois may bill their Medicare Part B Crossover invoices to their Medicare intermediary electronically. If the patient has Medical Assistance program coverage, and the Medicare intermediary has an arrangement with the Department, the services will automatically be crossed over to the Department for a determination of service coverage.

If the patient has Medical Assistance program eligibility and the service is not automatically crossed over to the Department, or the determination of Medical Assistance program eligibility is made after

the service was sent to Medicare, or the provider has not been notified by the Department of the disposition of a service which was automatically crossed over within 180 days of submittal to Medicare, the provider should submit the claim to the Department as a paper invoice with the necessary documentation. The necessary documentation must include, but is not limited to, the Medicare Explanation of Benefits which identifies to the Department that Medicare had previously adjudicated the service.

Mailing Instructions:

- When services are submitted to the Department on paper, the provider invoice envelope (DPA 1444) should be used.
- When services are submitted to the Department on paper with attachments other than the Medicare Explanation of Benefits, the Special Approval Envelope (Form DPA 1414) should be used.

This will ensure that the services are correctly routed for processing. See Appendix A-8 to order these envelopes.

A-202.4 PAYMENT

Payment made by the Department for allowable services provided to clients is based on the individual physician's usual and customary fees, within the limitations established by the Department. The maximum payment rates are the Statewide pricing screens as specified in procedure code systems adopted by the Agency.

For clients eligible for Medicare Part B benefits, payment will be considered on the deductible and coinsurance amounts and/or for Medical Assistance Program covered services not covered by Medicare. (See Chapter 100, Topic 122.14.)

A-202.41 Record Requirements

See Chapter 100, Topic 112, for record requirements applicable to all providers, including physicians. Physicians must maintain an office medical record for each Medical Assistance client. In group practices, partnerships, and other shared practices, one record is to be kept with chronological entries by the specific physicians rendering services.

The record is to include the essential details of the client's health condition and of each service provided. Any services provided a client by the physician outside the physician's office are to be documented in the medical record maintained in the physician's office. All entries must include the date and time and must be legible and in English. Records which are unsuitable because of illegibility or language may result in sanctions if an audit is conducted. Transcription may be required for purposes of peer, quality of care, or utilization reviews by the Department.

The record requirement for a consultation is a copy of the report which was made available to the physician requesting the consultation.

For clients who are hospitalized or in a long term care facility, the primary medical record indicating the client's health condition and treatment and services ordered and provided during the period of hospitalization or institutionalization may be maintained as a part of the hospital or facility chart; however, an abstract of the hospital or facility record, including diagnosis, treatment program, dates and times services were provided and recommendations, is to be maintained by the physician as an office record to show continuity of care.

The Department and its professional advisors regard the preparation and maintenance of adequate medical records as essential for the delivery of quality medical care. In addition, physicians should be aware that the medical records are a key document for post payment audits. In the absence of proper and complete medical records, no payment will be made and payment previously made will be recouped.

Department requirements on retention of records as stated in Topic 112.2 in Section I, Chapter 100, are applicable to x-rays and records of a film-like nature. The retention requirements are not intended to replace professional judgment nor do they supersede record retention requirements under law or regulations of other agencies. The physician may choose to retain records beyond the Department's required period.

The Department has no objections to microfilming x-rays when it is done in compliance with applicable State laws.

A-203 COVERED SERVICES

A covered service is a service covered under the Illinois Medical Assistance Program and for which payment can be made by the Department (see Chapter 100, Topic 102.1 and 102.2). Covered are those reasonably necessary medical and remedial services which are recognized as standard medical care required for immediate health and well-being because of illness, disability, infirmity or impairment.

While various procedure codes may be used to designate services provided or procedures performed, such usage does not necessarily assure payment. Any question a physician may have about coverage of a particular service is to be directed to the Department prior to provision of the service. See Appendix A-21 for addresses and telephone numbers to be used when making an inquiry.

A-203.1 NON-LOCAL REFERRALS

A physician may refer a client to a non-local participating source of medical care only if the care and service for which referral is made are medically necessary and covered under the Medical Assistance Program and are not available locally.

If the necessary services are available locally, and referral is made to a non-local provider for the preference or convenience of the physician or the client, the Department will not assume responsibility for related expenses involved, such as transportation costs, etc.

A-204 NON-COVERED SERVICES

Services for which medical necessity is not clearly established are not covered in the Medical Assistance Program. See Chapter 100, Topic 103 for services and supplies for which payment will not be made. In addition, the following physicians' services are excluded from coverage in the Medical Assistance Program and payment cannot be made from Title XIX funds for the provision of these services.

- Examination required for the determination of disability or incapacity. (Local Department of Human Services offices may request that such examinations be provided with payment authorized from nonmedical funds. Physicians are to follow specific billing instructions given when such a request is made).

- Services provided in Federal or State institutions.

- Sterilization of a mentally incompetent or institutionalized individual or an individual who is less than 21 years of age.

- Procedures performed to attempt to restore fertility subsequent to sterilization.

- Those prosthetic devices inserted or implanted which do not increase physical capacity, overcome a handicap, restore a physiological function or eliminate a functional disability. (NOTE: Does not apply to breast prosthetic devices provided following cancer surgery.)

- Autopsy examination.

- Preventive services, except those provided through the Maternal and Child Health Program for children through age 20 and those provided through the Drug Formulary.

- Artificial insemination.

- Abortion, except in accordance with IDPA Rule 140.413(a)(1).

- Medical or surgical transsexual treatment services.

- Subsequent treatment for venereal diseases when such services are available through State and/or local health agencies.

- Dietitian counseling.

A-210 LIMITATIONS ON COVERED SERVICES

The following services are covered in the Medical Assistance Program only when provided in accordance with the limitations and requirements specified.

A-210.1 PRIOR APPROVAL

Prior approval is required for the provision of certain physician services/items. Services/items requiring prior approval are identified in the specific topics of this handbook. See Chapter 100, Topic 104, for general information relating to prior approval provisions.

A-210.2 SERVICES AVAILABLE TO INDIVIDUALS THROUGH AGE 20

The University of Illinois Division of Specialized Care for Children (DSCC) provides for care and treatment of individuals from birth through age 20 who have conditions considered crippling or potentially crippling. See Section I, Chapter 100, Topic 121, for identification of these conditions.

Additionally, certain medical services are available to children without charge through private organizations.

These sources must be utilized for each individual who is eligible for those services.

The physician is to refer the individual to DSCC or to private organizations. If assistance in making the referral is needed, the local public assistance office may be contacted.

Any questions a physician may have about coverage of a particular service for individuals through age 20 may be directed to the Department prior to provision of the service. See Appendix A-21 for addresses and telephone numbers to be used when making an inquiry.

A-210.3 END STAGE RENAL DISEASE (ESRD) TREATMENT

Outpatient ESRD treatment services are defined by the Department as renal dialysis treatments and those other outpatient services that are directly associated with the dialysis treatments provided to persons designated by the Department of Health and Human Services as Chronic Renal Patients. These services may be provided by a hospital enrolled for the provision of such services, in or through a free-standing hospital-based dialysis center, in a patient's home, or in an approved "satellite" unit that is professionally associated with the center for the medical direction and supervision.

Reimbursement for continuing medical management of a maintenance dialysis patient may be made to a physician. Only the Dialysis Center may submit charges for home dialysis supplies.

The physician services covered by the payment must be in accordance with Medicare guidelines. Services include the routine pre-dialysis examination, physician attendance during a dialysis episode where the patient has a serious ailment, visits for routine evaluation of the patient's progress or for the treatment of renal disease complications and all renal related physician services provided by the attending physician, regardless of the place of service. Separate charges may be submitted for the insertion of grafts, shunts, de-clotting of shunts, and non-renal related physician services.

A-210.3 **END STAGE RENAL DISEASE (ESRD) TREATMENT** (Continued)

Charges for daily medical management services are not to be submitted for a date of service on which 1) the physician has submitted a charge for non-renal services; 2) the patient was under the care of another physician (i.e., temporarily transferred); 3) a charge was submitted for services excluded from the monthly payment; or 4) the physician has billed as a concurrent care physician.

If an ESRD patient is temporarily transferred to another physician for services covered by the monthly payment, charges are not to be submitted by the attending physician for the days that the patient is in the transferred status. The physician accepting the transferred patient may submit charges for the period that services are provided.

Charges may be submitted for a hospitalized ESRD patient even though specialized services, either concurrently or intermittently, are being provided by another physician. As an alternative, the physician providing continuing medical management may bill as a concurrent care physician for the period of hospitalization and bill for daily Medical Management for the balance of the month. See Topic A-284.2 for Concurrent Care policy and procedure.

A-210.31 **Non-Medicare Eligible Recipient**

PROCEDURE: The appropriate CPT procedure code for End Stage Renal Disease Related Services is to be used when billing for an uninterrupted month of service (one procedure code and one charge). **The last day of the month** covered by the monthly payment is to be shown as the date of service. Allow a minimum of 27 days to pass before billing the next month.

The appropriate CPT procedure code for End Stage Renal Disease related services (less than a full month) **per day** is to be used when billing on the Form DPA 2360, for less than a full month of Medical Management services. Separate entries, with the appropriate date of service, must be made for each daily charge submitted.

A-210.32 **Medicare Eligible Recipient**

PROCEDURE: Submit charges to Medicare according to program guidelines. See Chapter 100, Topic 122.14.

A-210.4 **PSYCHIATRIC SERVICES**

Psychiatric services are not covered services for recipients of Transitional Assistance or Child and Family Assistance (Category 07).

EXCEPTION: Children 17 years of age or younger are eligible to receive the full scope of Medical Assistance Program covered services.

A-210.4 **PSYCHIATRIC SERVICES** (Continued)

For most services, procedure codes in the CPT are applicable. For any applicable Department-generated procedure codes, see Appendix A-13.

Psychiatric therapies must be provided by the physician who submits charges. Services provided by a psychologist, social worker, etc., are not reimbursable.

EXCEPTION: When a client receives a psychotropic drug injection only at the time of an office visit, it is considered a minimal office visit.

PROCEDURE: CPT procedure code 99211 is to be used when charges are made for visits for psychotropic drug injections only. An additional charge may be made for the cost of the psychotropic drug given.

Payment will be allowed for only one psychiatric service per day.

EXCEPTION: Payment will be allowed for 2 psychiatric services when one of the services is Electroconvulsive Therapy (ECT).

When charges are submitted for basic daily inpatient care, State generated procedure code W7464 is to be billed. Basic daily inpatient care consists of a therapeutic encounter with the patient and must include one of the following services or an equivalent:

- Medical psychotherapy which may include, but is not limited to psychoanalysis; insight oriented therapy; behavior modification; supportive therapy.
- Continuing medical/psychiatric diagnostic evaluation.
- Psychotropic drug management.
- Supervision and management of the patient's treatment program which may include providing guidance and direction to hospital employees involved in the patient's treatment program and/or participation in conferences to plan treatment program.
- Communication with significant others to facilitate patient compliance with hospital treatment and after care.

Other codes for more involved procedures may be used in lieu of basic daily inpatient psychiatric care. In such instances, the patient's record must contain a justification for the use of the more detailed procedure, an indication of the amount of time spent, and a brief description of the service provided.

PROCEDURE: Charges are to be billed to the Department of Public Aid on Form DPA 2360, Health Insurance Claim Form, following general instructions for bill preparation and mailing as described in Appendix A-1.

A-210.4 **PSYCHIATRIC SERVICES** (Continued)

In addition to the record requirement in Topic A-202.41, the patient's record is to show the actual time spent in direct patient care, not including the time required for documenting the record, making reports, etc. If time is not shown on a patient's record and an audit is conducted, the absence of documentation may result in recoupments of payments based upon the consistency of services rendered versus the time associated with procedures billed.

Length of stay for inpatient hospitalization is controlled by the hospital's utilization review authority.

See Topic A-260 for policy regarding psychiatric consultations.

A-210.5 **ABORTION, STERILIZATION, AND HYSTERECTOMY**

A-210.51 **Termination of Pregnancy - Induced Abortions**

An induced abortion is a covered service only when, in the professional judgment of a licensed physician, the life of the mother would be endangered if the fetus were carried to term, or if the pregnancy is the result of rape or incest, or to protect the mother's health.

= To receive payment for abortions as described in the preceding paragraph, a provider must complete Form DPA 2390, Abortion Payment Application, and submit it with the billing statement. (See Appendix A-4). As appropriate, copies of the DPA 2390 are to be made available to the hospital to submit with claim form UB-92.

= To order a supply of Form DPA 2390, follow ordering instructions found in Chapter 100, General Policy and Procedures, General Appendix 10 or the physician may make a copy of the DPA 2390 found in Appendix A-4a to submit with the billing statement.

= The Department will reimburse for a surgical abortion or the use of the drug Mifepristone to terminate a pregnancy in the circumstances described above. When billing for an induced abortion covered by the Department, use the appropriate procedure code found in Appendix A-4a on the DPA 2390. The procedure code on the claim must match the procedure code on the attached DPA 2390; otherwise, the claim will be returned as unprocessable.

When performing a surgical abortion one all-inclusive charge is to be made for the total service provided.

= When a physician prescribes Mifepristone to induce an abortion, the Department will reimburse the physician a global rate for all three visits required to complete the procedure. The three visits consist of the initial visit, the two day follow-up and two week follow-up required under the Food and Drug Administration's protocol for the use of this drug. The physician may bill the Department after the first visit. In the event that the patient does not return for the follow-up visits, and seeks treatment from another physician, the Department will not require a refund of the global payment made after the first office visit. In this situation, the physician providing the follow-up services should use the appropriate CPT code to bill for the visit.

= Charges for any tests performed, such as an ultrasound or beta test, must be billed using the appropriate CPT code. Procedure code S0190 must be used to bill for the drug Mifepristone taken at the first visit. Procedure code S0191 must be used to bill for the drug Misoprostol taken at the second visit.

A-210.52 **Sterilization**

Sterilization is a covered service only for individuals, male or female, who have given written consent, are at least 21 years old at the time consent is obtained, and are not institutionalized or mentally incompetent. At least 30 days, but not more than 180 days, must have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery.

In cases of emergency abdominal surgery or premature delivery, the informed consent must have been obtained not less than 72 hours prior to the sterilization procedure.

Informed consent may not be obtained while the individual to be sterilized is:

1. In labor or childbirth,
2. Seeking to obtain or obtaining an abortion, or
3. Under the influence of alcohol or other substances that affect the individual's state of awareness.

PROCEDURE: Written consent to perform a sterilization must be obtained on Form DPA 2189, Consent Form (see Appendix A-3). All appropriate sections of the form are to be completed. See Appendix A-1 for the explanation of entry to be made in Field 23C of Form DPA 2360, Health Insurance Claim Form.

Form DPA 2189 must be attached to Form DPA 2360, Health Insurance Claim Form, when charges are submitted. Failure to comply will result in denial of payment. The claim with attachment is to be mailed in the Special Handling Envelope, DPA 1414.

NOTE: If charges are submitted without the DPA 2189, payment for the services will be denied.

The appropriate code which describes the procedure performed is to be selected from the current CPT.

As appropriate, copies of the completed consent form are to be made available for the hospital to submit with its billing statement, and to other physicians who are submitting a billing statement for services associated with the procedure.

When a tubal ligation is performed following a vaginal delivery or a Cesarean section, payment will be made for the tubal ligation in addition to the delivery.

When the sterilization is performed in a hospital by a salaried hospital staff physician, the signed Form DPA 2189, is to be attached to the hospital billing statement.

A-210.53 **Hysterectomy**

A hysterectomy is a covered service only when, in the physician's professional judgment, it is not done solely to accomplish sterilization, but is done for other medical reasons. If there is more than one purpose to the procedure, the physician must certify that 1) the hysterectomy is not being performed solely to accomplish sterilization but is being performed for other medically necessary reasons **or** 2) one of the following exceptions:

- The patient was already sterile at the time of the hysterectomy.
- The patient had the hysterectomy under a life-threatening emergency situation in which prior acknowledgment of receipt of hysterectomy information was not possible.
- The patient had a hysterectomy performed during a period of retroactive eligibility, and the patient was advised that the operation would render her permanently incapable of reproducing, or exceptions 1 or 2 described above made such explanation unnecessary or impossible.

When the procedure is a covered service, payment for the services provided will be made only when the Department receives signed documentation as evidence that the individual or her representative has been informed orally and in writing prior to the surgery that the procedure will render the individual permanently incapable of reproducing. Form DPA 1977, Acknowledgment of Receipt of Hysterectomy Information, has been designed for the physician's use. The form requires the patient's (or representative's) signature, the interpreter's signature (if required) and the signature of the physician. All signatures must be dated.

EXCEPTION: The patient's (or representative's) signature is not required if one of the exception statements on the DPA 1977 has been completed by the physician.

PROCEDURE: A copy of the completed Form DPA 1977 must be attached to the Form DPA 2360, Health Insurance Claim Form submitted for the service. (See Appendix A-2.) The procedure code entered on the claim is to be the code for the procedure, as described in the current CPT.

When a hysterectomy is performed in a hospital by a salaried hospital staff physician, the signed Form DPA 1977 is to be attached to the hospital billing statement.

As appropriate, copies of the completed acknowledgment are to be made available for the hospital to submit with their billing statement, and to other physicians who are submitting a billing statement for associated services.

A-210 **LIMITATIONS ON COVERED SERVICES** (Continued)

A-210.6 **ORGAN TRANSPLANTS**

The Medical Assistance Program provides for payment for organ transplants only when provided by a Certified Transplantation Center as described in 89 Illinois Administrative Code 148.82 (c) through (h).

Bone Marrow, heart, heart/lung, lung (single or double), liver, pancreas, kidney/pancreas and other types of transplant procedures may be covered provided the hospital is certified by the Department to perform the transplant.

A-220 OFFICE SERVICES

Charges may be made for covered medical and surgical services provided by a physician in the physician's office which are essential for the diagnosis and/or treatment of a specific illness, surgical condition, or injury.

When a therapeutic procedure is performed, reimbursement will be made for either the visit or the procedure, but not for both unless it is an initial visit. All office services for which charges are made must be documented in the client's office medical record.

Except for visits for family planning services (see Topic A-250) and Maternal and Child Health services, the types of office visits recognized by the Department are those listed in the CPT. The selection of an office visit code is to be based on the level of service provided, and whether the visit is for a new or an established patient. A client may be designated as a new patient only one time by an individual physician. In partnership or group practices, new patient designation is allowed only one time collectively for all physicians in the group regardless of the number of physicians in the group who eventually may see the client.

For billing and audit purposes, the requirements the Department has adopted for use of the CPT Evaluation and Management codes are outlined in your CPT.

A-220.1 REFERRAL (TRANSFERRED PATIENT)

A referral is the total transfer of medical care of a client from one physician to another physician who then assumes complete and direct care of that client with respect to a specific diagnosis and/or treatment.

Code the transferred patient and the initial visit as a new patient to that physician.

When a patient is transferred within a group practice setting, a new patient procedure code is not to be used. The visit is classified as for an established patient. Coding is to be consistent with the complexity of the condition.

A-221 PHARMACY ITEMS

A-221.1 PRESCRIPTION REQUIREMENTS

Pharmacy items which are essential for the accepted medical treatment of a client's presenting symptoms and diagnosis are covered items for which payment can be made by the Department, when they are prescribed or dispensed in accordance with the following requirements and limitations.

Coverage of prescription pharmacy items and over the counter drugs is limited to those produced by drug manufacturers who have signed drug rebate agreements. A listing of rebating manufacturers is distributed quarterly by the Department. Pharmacy items, both prescription and over-the-counter items, which are covered in the Medical Assistance Program may be prescribed or dispensed in accordance with specified policy and procedure.

= The physician is to use the physician's own prescription form and is responsible for entering on the form the following minimal information:

- Client's name
- Date of prescription
- Name of pharmacy item being prescribed
- Dosage form and strength or potency of drug (or size of non drug item)
- Quantity
- Directions for use
- Refill directions
- Physician's Medical Assistance program Identification Number/License Number
- Signature in ink and legible
- Drug Enforcement Administration (DEA) Number (or the Social Security Number of those physicians who do not have a DEA Number.)

Physicians may not charge for the writing of prescriptions.

Prescriptions are not to be written for injectables which are to be given in the physician's office unless the acquisition cost of the injectable equals or exceeds $25.00.

Physicians are to prescribe, and pharmacies are to dispense, medications in quantities reasonably calculated to meet the predictable needs of the patient as long as this does not exceed the designated maximum quantity.

Patients who are on extended maintenance therapy defined as prolonged use of the same drug, strength, and daily dosage quantity should be issued prescriptions for a 30 day supply per dispensing. The exception to this policy is for birth control pills for which up to a 90 day supply may be dispensed.

The completed prescription form is to be given to the client to take to the pharmacy of the client's choice; however, a physician may telephone or electronically transmit a pharmacy to prescribe, provided that the client is permitted free choice of pharmacy.

A-221 **PHARMACY ITEMS** (Continued)

A-221.1 **PRESCRIPTION REQUIREMENTS** (Continued)

The client's medical record in the physician's office is to contain entries regarding all drugs, medications with dosages, and medical supplies which are prescribed or dispensed, and the patient's response to the treatment. When medications are dispensed to a client, the physician shall comply with all aspects of Section 33 of the Medical Practice Act, particularly those relating to prescription labeling and record keeping.

A-221.2 **DISPENSED ITEMS**

Charges may be submitted for drugs dispensed in an emergency, or when not readily obtainable from a pharmacy.

PROCEDURE: The specific drug dispensed is to be identified in Field 24C of the Form DPA 2360 with the appropriate Item Number from the Department Drug Manual (Section IV of the Handbook). The number of tablets/capsules dispensed is to be shown on the claim in Days/Units Field 24F.

= When an injectable is supplied and administered by the physician, the appropriate CPT or HCPCS procedure code is to be entered in Field 24C of the Invoice. The drug name, strength, and quantity must be shown in the narrative sections of the invoice.

See Appendix A-1, Field 24C and 24F for detailed billing instructions for dispensed drugs.

For drug items specifically coded, reimbursement will be made in the amount of the charge, not in excess of the Department's maximum or established acquisition costs. Whether dispensed by the physician or pharmacy, the brand name version of a drug available generically is reimbursed at the reimbursement rate for the generic unless prior authorization for the branded version is obtained. Drugs are considered available generically if they are listed in the Illinois Department of Public Health’s Illinois Formulary for the Drug Product Selection Program.

No charges may be made for anesthesia agents administered for office surgical procedures or for sample items dispensed.

A-221.3 **EXCEPTIONS**

Limitations apply for clients eligible for the Child and Family Assistance Program or for the Transitional Assistance Program, category 07.

A-221 **PHARMACY ITEMS** (Continued)

A-221.3 **EXCEPTIONS** (Continued)

NOTE: Children ages 17 or younger, in Child and Family Assistance cases, in the City of Chicago are eligible to receive the **full** scope of Medical Assistance program covered services.

A-221.4 **PRIOR AUTHORIZATION**

Prior authorization is required for certain drugs covered by the Medical Assistance Program. Prior authorization requests must include the following information:

1) The drug requested must be from a rebating drug manufacturer.

2) The drug requested must be used in accordance with accepted medical standards and the following compendia:

- American Hospital Formulary Service Drug Information,
- United States Pharmacopeia Drug Information,
- American Medical Association Drug Evaluations, or
- DRUGDEX information system.

3) The physician must document that the drug requested is necessary to prevent a life threatening situation and that items covered without prior authorization under the Medical Assistance Program are not effective to maintain the patient or avoid a life threatening situation.

Prior authorization may be used to request exceptional quantities of medication so long as medical documentation supports the need.

Requests for prior approval may be initiated by the prescribing physician or office personnel under the physician's direct supervision. The Department will also accept requests from a pharmacist, social worker, or other individual who is making the request at the direction of a practitioner licensed to prescribe under applicable State laws.

In emergency situations or for the first time that prior approval is requested for a prescription, the practitioner or representative may call the toll-free number, 1-800-252-8942, to request prior approval.

A listing of the prescription and over the counter items coverable in the Medical Assistance Program and which require prior authorization may be requested by writing the Department at the address listed below. Written requests may also be telefaxed to 217-524-0404.

The following information is needed in order to review requests for authorization:

- client I.D. number
- diagnosis
- requested drug (strength, dosage, quantity, number of refills authorized)
- days supply

A-221.4 **PRIOR AUTHORIZATION** (Continued)

- drug(s) and/or other therapy previously used for treatment of this condition
- identification of the prescribing physician and the dispensing pharmacist (if known) by name, address and provider number
- when the request is for the brand name version of a drug available generically, it must also include medical information regarding the lack of effectiveness of the generic

Requests for prior authorizations may be telephoned to 800-252-8942, telefaxed to 217-524-0404 or submitted in writing to:

Illinois Department of Public Aid
Attention: Drug Unit - Prior Approval
Post Office Box 19117
Springfield, Illinois 62794-9117

Renewals of previously granted prior authorizations are to be submitted by telefax or in writing.

The Department's approval will specify the length of time for which approval is granted. The physician is responsible for requesting a renewal of an approval when a prescription is necessary for subsequent periods.

Allowable items should be prescribed in monthly quantities. If a monthly quantity exceeds the Department's established maximum, prior authorization for the excessive quantity must be requested.

Approval for a drug prescribed in excess of the maximum quantity is for the period of time specified on the approval. The physician must obtain approval to continue prescribing the drug in excess of the maximum quantity beyond the previously established approval period.

A-221.5 **NON-COVERED PHARMACY ITEMS**

Pharmacy items which may not be covered by the Department are:

- Items not included in the Drug Manual (except for Prior Approval and/or Special Authorization)
- Anorectic drugs or combinations including such drugs
- Smoking cessation products
- Biologicals and drugs available without charge from the Illinois Department of Public Health or other agencies (see Appendix A-15)
- A vaccine, drug, or serum which is provided primarily for preventive purposes. This exclusion does not apply to items for clients covered under the Maternal and Child Health Program which are not supplied to the physician by the Vaccine for Kids program. Specific exceptions to this situation may be obtained by contacting the Department.
- Vitamin B12 or liver extract, except for patients with macrocytic anemia, e.g., pernicious anemia, post gastrectomy anemia, diabetic neuropathy and herpes zoster, the diagnosis of which is established on the basis of hematological studies

A-221 **PHARMACY ITEMS** (Continued)

A-221.5 **NON-COVERED PHARMACY ITEMS** (Continued)

- Prescription or over the counter drugs for use in treating the common cold and its side effects
- Injectable drugs, when equally effective oral preparations are available
- Items such as dental products, hair products, facial tissues, infant disposable diapers, sanitary pads, tampons, soap or other personal hygiene products, articles of clothing or cosmetics of any type, proprietary food supplements or substitutes, sugar or salt substitutes, or household products
- Infant formula, except for an infant requiring a non-milk base product because of an allergic reaction to the usual infant products

A-221.6 **MEDICAL SUPPLIES**

Medical supplies (i.e., rubber gloves, colostomy supplies, tracheostomy supplies) are those items which are not durable or reusable as opposed to sickroom needs and medical equipment items (see Topic A-221.9). Coverage is limited to those items that are required following a treatment plan for a specific medical condition. Medical supplies are not to be dispensed or prescribed for a client's personal convenience.

A-221.7 **HOME MEDICINE CHEST ITEMS**

Home medicine chest items may be prescribed only when a client's need for a specific item is extended or the item is necessary in large quantities for a specific therapeutic reason. Such items include, but are not limited to: throat lozenges, laxatives, petroleum jelly, gauze, adhesive tape, rubbing alcohol, etc.

NOTE: Prior approval is required for reimbursement for home medicine chest items.

A-221.8 **GROUP CARE RESTRICTED ITEMS**

Pharmacy items identified as Group Care Restricted Items may not be prescribed or dispensed for clients living in licensed long term care facilities. Payment to the facility includes payment for the provision of such items.

A-221.9 **SICKROOM NEEDS AND MEDICAL EQUIPMENT ITEMS**

Sickroom needs and medical equipment items are considered to be those relatively durable, reusable articles which are required to enable a client to receive in-home care and/or to maintain the client's level of functioning in the community. Included in this category are such articles as: ice bags, heating pads, vaporizers, bedpans, crutches, walkers, wheelchairs, etc.

When the physician determines that an individual has a medical need, an order may be written. The supplier will be required to obtain prior approval from the Department before reimbursement can be authorized.

A-222 MEDICAL DIAGNOSTIC AND TREATMENT SERVICES

A-222.1 LABORATORY TESTS

Only those laboratory tests and examinations which are essential for diagnosis and evaluation of treatment are covered. Batteries of "rule-out" tests are not covered.

A physician may charge only for those tests performed in the physician's office by the physician's staff, using the physician's equipment and supplies. Payment made by the Department for laboratory tests performed in the physician's office includes both the professional and technical component fees.

A central laboratory serving physicians in group practice is considered a physician's office laboratory.

When the recipient presents for laboratory tests only, an office visit charge may not be made.

Physicians providing laboratory services in an office setting must be in compliance with the Clinical Laboratory Improvements Amendment (CLIA) Act. For more information on laboratory registration, permits and/or full licensure, you may contact:

Illinois Department of Public Health
Division of Health Care Facilities and Programs
525 West Jefferson Street, Fourth Floor
Springfield, Illinois 62761.

The appropriate procedure code is to be used when billing for office laboratory tests. When an "Unlisted Procedure" code is used, a complete description of the test must be shown on the claim or an attachment to the claim. The specific test performed must be identified in order for payment to be made for "Unlisted" codes.

Laboratory analysis for lead screening is conducted by the Illinois Department of Public Health, Division of Laboratories, 825 North Rutledge, P.O. Box 19435, Springfield, Illinois 62794-9435.

NOTE: A physician may not charge for laboratory tests performed by any outside laboratory. Charges are not to be made when a specimen is obtained but sent out of the office, e.g., skin lesions, pap smears, etc.

A-222.11 Organ or Disease Oriented Panels

CPT procedure codes 80049 through 80092 may be used in lieu of individual codes to report "organ panels", e.g., Hepatic Function Panel, Thyroid Panel, Arthritis Panel or profiles that combine tests under a problem oriented classification such as Obstetric Profile and Lipid Profile. Do not submit charges for individual or profile codes for tests included in the panel(s) billed, and vise versa.

Payment is allowable for Vitamin B12/Folic Acid testing only when the possibility of Vitamin B12 deficiency is indicated after the presence of macrocytic anemia is detected by a complete blood count. CBC test results must be attached to the claim when charges are submitted for Vitamin B12/Folic Acid testing.

For necessary laboratory tests not provided in the physician's office, the physician is to make written referral to 1) the outpatient department of a participating hospital, 2) a pathologist in private practice, or 3) a Medicare certified independent laboratory.

The physician must specify the test ordered when referring to a lab not in the physician's office. Blanket, "rule-out", or open-ended requests are not allowed. The physician must use discretion in ordering only those laboratory tests necessary and pertinent to the condition which the physician is treating. The physician is to include the client's diagnosis or presenting symptoms which indicate the need for the specific tests ordered. The physician's State License Number must be available to each laboratory to which referrals are made.

The physician may not charge for making a referral, for collection or sending of a specimen for analysis, or for tests ordered, e.g. pap smears. The actual provider of services is to make charges directly to the Department and provide a written report of test results to the physician for filing in the client's medical record.

NOTE: An additional charge may be made for a Pap smear only if the laboratory examination is performed in the physician's own office laboratory.

A pathologist in private practice may charge for the specific tests and examinations provided; however, an additional office visit charge may not be made. If the pathologist has an office laboratory certified by Medicare as an independent laboratory, independent laboratory policy and procedure apply. Refer to Chapter L-200, Handbook for Laboratories, for further information.

A hospital-based pathologist may submit charges to the Department for professional services in conjunction with referred laboratory services only if the pathologist's contractual agreement with the hospital provides for separation of charges and the hospital does not bill for the professional component.

PROCEDURE: Charges for the professional component of laboratory services are to be submitted on Form DPA 2360 with appropriate procedure codes. The place of service is to be shown as "2" or "22" Outpatient Hospital, "E" or "23" Emergency Room, or "1" or "21 Inpatient Hospital, as appropriate.

If charges are submitted for multiple occurrences of the same procedure on the same date of service, complete a single service section entering the number of occurrences in the "Days/Units" field in a 4-digit format. Example: 2 = 0002.

NOTE: Six or more occurrences requires a narrative explanation or copies of lab reports as documentation.

NOTE: Certain laboratory tests are limited to a quantity of one (1) per day due to the nature of the procedure, e.g., cytopathology (Pap smears), surgical pathology, chromosome analysis, etc. If more than one test is performed at separate times on the same day for the tests which are limited to one (1), the appropriate code is to be shown with the charge for one (1) test and the appropriate "unlisted" code used with one all inclusive charge for the additional test(s).

The description field of the claim, or an attachment to the claim, must clearly define the reason for use of the unlisted code, e.g., "three additional specimens for surgical pathology".

A-222.12 **Automated Multichannel Tests/Panels**

Profile test codes 80002 - 80019 were deleted from the 1998 CPT. The Department follows HCFA's guidelines regarding procedures for billing multiple chemistries. Organ or Disease Oriented Panel codes should be used only when all of the tests listed in the panel definition are performed. When not all of the tests listed are performed, individual test codes are to be used and a separate charge shown for each code. Individual codes are also to be used for automated tests that are not included in a panel code.

A-222.13 **Therapeutic Drug Monitoring**

Measurement of one or more drugs in body fluids and/or excreta may be billed under the specific procedure code for the drug(s) test. If no specific drug code exists, the unlisted Drug Assay code is to be used. When the unlisted code is used, the specific drug(s) tested for must be entered in the description field of Form DPA 2360. A copy of the test reports or a narrative listing of the drug(s) included in the charge may be attached.

A-222.14 **Viral Load Testing**

Effective for service dates on or after September 1, 1996, payment is allowed for Viral Load Testing.

PROCEDURE: CPT unlisted code 84999 must be used to bill for this service for service dates 09-01-96 through 12-31-97. ("Viral Load Testing" must be shown in the description field on the claim when the unlisted CPT code is used.) For service dates 01-01-98 and after, CPT code 87536 is to be used.

When this service is billed by a physician with "office" as the place of service, a copy of the laboratory report must be submitted with the claim. **Payment will not be made to a physician for testing that is performed by an outside laboratory.**

A-224 RADIOLOGICAL SERVICES

Radiological and x-ray services are covered when essential for the diagnosis and treatment of disease or injury. Routine screening x-rays are not covered. (For an exception regarding mammography, see Topic A-225.1.)

PROCEDURE: The physician may submit charges for the professional component of radiology services on Form DPA 2360 with appropriate procedure codes. Code the place of service as either "2" or "22" outpatient hospital, "1" or "21"inpatient hospital, or "E" or "23" Emergency Room.

If charges are submitted for multiple occurrences of the same procedure on the same date of service, use a single service section with the number of occurrences being entered in the "Days/Units" field (4 digit format).

NOTE: Six or more occurrences requires a narrative explanation or copies of x-ray reports as documentation.

Certain x-rays are limited to a quantity of one (1) per day due to the nature of the service, e.g., angiography, gallbladder, upper GI series, etc. If the procedure is repeated at a separate time on the same day, the “unlisted” code is to be used with a separate charge and an explanation of the service in the description field of the claim or on an attachment to the claim.

A physician may charge only for x-ray examinations provided in the physician's own office, by the physician's staff, using the physician's equipment and supplies. When x-rays only are provided at the time of an office visit, an office visit charge may not be made. A central x-ray department serving physicians in group practice is considered the physician's office.

A-224.1 REFERRAL

The physician may make written referral to a hospital outpatient department or to a radiologist in private practice for a client to have x-ray examinations or therapy. When referral is made, the physician must specify the x-rays ordered. Open-ended requests are not allowed. The physician may not charge for the act of referring a patient. The actual provider of services is to bill the Department for the services. The payment for x-rays includes the provision of a written report to the referring physician. The referring physician is to file the written report in the client's medical record.

A-224.2 PRIVATE PRACTICE RADIOLOGY SERVICES

A radiologist in private practice may charge only for the specific x-ray examinations or radiation therapy provided in accordance with requests of the referring physician. Additional charges for visits or services, such as dosage calculations, port plans, field settings, etc., are not reimbursable. The radiologist is to maintain in the patient's medical record file, the x-ray file, the referral and a copy of the report.

A-224.3 HOSPITAL-BASED RADIOLOGY SERVICES

A hospital based radiologist may submit charges to the Department for professional services in connection with referred x-ray services only if the radiologist's contractual agreement with the hospital provides for separation of charges and the hospital does not bill for the professional component. Any interpretation of x-rays or tests which are not directly related to patient care are not reimbursable.

A-224.4 ULTRASOUND IMAGING

Ultrasound imaging, scanning, echograms or sonograms are covered when medically necessary. Routine screening or surveys are not allowed, nor are "rule-out" examinations unless a specific differential problem exists.

When a charge is made for ultrasound examinations, an additional charge can not be made for radiographic examinations of the same area or systems unless adequate justification is given for both procedures.

A-224.5 SURGICAL/DIAGNOSTIC PROCEDURES REQUIRING RADIOLOGICAL SUPERVISION/INTERPRETATION

When a radiologist performs a specific procedure, e.g., catheter insertion, biopsy, injection, angioplasty, **and** radiological supervision and interpretation, two separate codes and charges should be submitted. The charges for the procedure and the radiological supervision/interpretation are to be shown on the same claim with T.O.S. code 4 (Field 23E).

NOTE: If the procedure is performed percutaneously and no specific code is available, the physician is to use the unlisted code for the pertinent body system.

Radiologists are not to use incisional procedure codes for procedures done percutaneously.

A-224.6 MAGNETIC RESONANCE IMAGING (MRI)

Reimbursement is made to the physician for interpretation of MRI procedures provided in a hospital setting. When the service is provided in a facility which is not considered a part of a hospital, reimbursement is made to the radiologist for the complete procedure. **Payment is allowed for only one complete MRI procedure per day per patient**.

PROCEDURE: When the service is provided in a facility which is not considered a part of a hospital, the MRI procedure is to be billed as a complete procedure on DPA 2360, Health Insurance Claim Form, under the name and provider number of the radiologist. Use the appropriate CPT procedure code.

Charges for the interpretation only of an MRI provided in the hospital setting are billed under the physician's own name and number using procedure code Y2926.

A-225 CANCER DETECTION

A-225.1 MAMMOGRAPHY SCREENING

Mammography screening is a covered service when ordered by a physician for screening by low-dose mammography for the presence of occult breast cancer. Coverage for this service is available under the following guidelines:

1) A baseline mammogram for women 35 through 39 years of age;

2) A mammogram once per year for women 40 years of age or older.

For purposes of this policy, "low-dose mammography" means using equipment which is specifically designed for mammography and which meets appropriate radiologic standards for mammography.

The physician who orders the mammography screening is responsible for the referral of the patient to a qualified radiologist. Prior to referral, the ordering physician is to perform a physical breast examination, provide instruction on self-examination and provide information regarding the frequency of self-examination and its value as a preventative tool.

The ordering physician is also required to: a) document in the patient's record the name of the facility where the mammogram was performed; b) maintain a copy of the report from the radiologist; c) report the screening results to the patient; and d) note in the patient's record any known transfer of mammograms to another facility or physician.

The radiologist is required to: a) maintain the mammography x-rays; b) examine them as to any condition requiring further diagnostic or treatment services; c) provide a detailed written report of mammography findings to the ordering physician; and d) transfer a copy of the x-rays, and other applicable records, to a new physician or medical institution when requested because the patient has transferred to another medical provider.

PROCEDURE: Department code W7699 is used to bill for the first mammography screening (baseline). The earliest patient age for the baseline screening is 35, but it could occur at any time through age 39. However, if the patient is older than 39 when the first screening is done, code W7699 is still to be used to bill the baseline screening. Use the most current CPT code to bill for any mammography screening subsequent to the baseline screening.

A-225.2 PAP TESTS AND PROSTATE-SPECIFIC ANTIGEN TESTS

Coverage is provided for the following:

1) An annual cervical smear or Pap smear test for women.

2) An annual digital rectal examination and a prostate-specific antigen test upon the recommendation of a physician licensed to practice medicine in all its branches, for:

A-225 **CANCER DETECTION** (Continued)

A-225.2 **PAP TESTS AND PROSTATE-SPECIFIC ANTIGEN TESTS** (Continued)

a) Asymptomatic men age 50 and older;

b) African-American men age 40 and older; and

c) Men age 40 and older with a family history of prostate cancer.

PROCEDURE: When billing the smear tests for women or the prostate-specific antigen test for men, use the appropriate CPT code for the individual service. Reimbursement for a digital rectal examination is included in the payment of the office visit.

A-226 PHYSICAL THERAPY

The physician may charge for essential physical therapy provided in the physician's office, by the physician or the physician's staff under the physician's direct supervision.

When physical therapy services are provided and the recipient is not seen by the physician, an office visit charge may not be made.

A-227 PULMONARY SERVICES

The physician may charge for essential pulmonary tests/procedures when provided in the physician's office, by the physician or the physician's office staff under the physician's direct supervision.

The client's office medical record is to include reports of appropriate pulmonary function tests, indication of medical need for procedures, and the client's response to treatment given.

When pulmonary tests and/or procedures are performed and the recipient is not seen by the physician, an office visit charge may not be made.

A-228 **ALLERGY SERVICES**

Allergy sensitivity tests and desensitization services provided by a physician are covered when documented in the client's medical record.

The initial office visit for allergy investigation is considered a comprehensive office diagnostic visit. Appropriate skin tests, sputum and nasal secretion studies and other essential services are covered.

PROCEDURE: CPT procedure codes listed under **Allergy Testing** are to be used for allergy sensitivity tests. Enter in Field 24C, of DPA 2360, the CPT procedure code which coincides with the number of tests performed.

Enter in Field 24F (Days or Units) the actual number of tests provided. This entry must be in a four digit format, e.g., the entry for thirty (30) tests is shown as 0030.

EXCEPTION: No entry should be made in Field 24F (Days or Units) for the following codes: 95060, 95065, 95070, 95071, 95075, 95078. A brief description and the number of tests should be entered in Field 24C.

After the initial office visit, appropriate established patient office visit codes may be billed. However, procedure code 99211 must be used when the reason for the visit is for the client to receive desensitization (allergy injections) only.

PROCEDURE: CPT procedure code 99211 is to be used when charges are made for visits for allergy injections only. An additional charge may be made for the cost of the allergy extract given. Appropriate CPT allergen or immunotherapy codes are to be used.

When more than one allergy injection is administered on the same date of service, procedure code 95199 (Unlisted Allergy Service) is to be used with a separate charge which includes all the additional injection(s) and a description of the service entered in Field 24C. Please specify the number of additional injections.

When an allergist prepares a vial of extract and provides it to another physician for administration, the allergist may make a charge for the vial(s) of extract. **The administering physician may not bill for the cost of the allergy extract, only the injection.**

PROCEDURE: The appropriate CPT procedure code for allergen immunotherapy vials is to be used for the first vial. The "unlisted" allergy service code is to be shown with a second charge for the additional vial(s). The service description and number of additional vials is to be entered in Field 24C.

A-229 **CHEMOTHERAPY FOR MALIGNANT DISEASE**

= Payment for chemotherapy administration may be made to physicians, APN, (when administered in accordance with the Nursing and Advanced Practice Nurse Act, 225 ILCS 65), and to hospitals billing fee-for-service. Physicians and APNs may bill for the administration of chemotherapy in the office, hospital inpatient, hospital outpatient and emergency room settings. Hospitals may bill fee-for-service for the administration for office, hospital outpatient and emergency room settings.

Only one administration fee per day is reimbursed, even when multiple drugs are administered. No payment is made for venous or arterial puncture performed for the purpose of administering the chemotherapy. Separate payment is allowed for an initial visit the day of chemotherapy administration, however follow-up visits are included in the chemotherapy administration fee.

Physicians and hospitals may make separate charges on Claim Form DPA 2360 for the chemotherapy agents or drugs and non-chemotherapy injectable drugs given with the chemotherapy and related supplies. The drugs and supplies are payable to physicians for the office setting only. Hospitals may bill fee-for-service for the drugs and supplies for office, hospital outpatient and emergency room. Hospitals may bill on the DPA 2360 Claim Form for the drugs and supplies even if no administration fee is billed. Anti-emetic drugs are types of non-chemo drugs usually administered with chemotherapy. **NOTE:** A DPA 215 Pharmacy Claim should be not be submitted for the drugs or supplies used in the administration of the chemotherapy.

PROCEDURES:

Chemotherapy Administration: Use the appropriate CPT code for the method of administration with a single charge for each date of service.

Chemotherapy Drugs: Use the CPT code for "provision of chemotherapy agent" (96545) and show one total charge for each date of service. The drug name, strength or potency and dosage/quantity for each drug given must be entered in the description field of the claim (24C) or on an attachment to the claim. The NDC number(s) may also be shown, if available.

Non-chemotherapy drugs: Code 90782 is to be used for the first subcutaneous or intramuscular injection of a non-chemotherapeutic drug administered with the chemotherapy for each service date. Code 90784 is to be used for the first intravenous injection of a non-chemotherapeutic drug. If more than one non-chemo drug is administered by either or both of these methods of injection, the unlisted code (90799) must be shown with one charge per service date for all the additional drugs given. The drug name, strength or potency and dosage/quantity for each drug given must be entered in the description field of the claim (24C) or on an attachment to the claim. The NDC number(s) may also be shown, if available.

Supplies: Use CPT code 99070 one time per service date with one total charge for all covered supplies used for the chemotherapy session. Examples of payable supplies are IV solutions, needles, IV tubing, and venosets. A complete description of each supply used must be shown in the description field (24C) or on an attachment to the claim.

NOTE: If an attachment is used to identify or describe the chemo and non-chemo drugs and supplies, please separate the items by type of drug, i.e. chemo or non-chemo or supplies.

A-230 SURGICAL SERVICES

Certain designated procedures are eligible for additional reimbursement if the procedure is provided in the physician's office. (See Appendices A-17, A-18 and A-19.)

PROCEDURE: The CPT procedure code for the specific surgical procedure is to be entered in procedure code field. The lesion size, number of sutures, procedure method of removal is to be provided on the description line. (All charges for tissue examination on removed lesions must be made by the laboratory.)

A-230.1 ANESTHESIA

When an office surgical procedure requires the administration of local anesthesia, no additional charge may be made for the anesthesia agent or for the administration, as both are considered a part of the operative procedure.

A-230.2 DRESSINGS

For customary surgical dressings no charges may be made in addition to office visit or procedure charge. For dressings which are unusually expensive or required in large amounts, e.g., medicated dressings, charges may be made if substantiating clinical data is submitted with the claim.

A-230.3 BURN TREATMENT

Charges may be made for surgical debridement and dressings for burns, when substantiating information is submitted. No additional charge may be made for the office visit.

PROCEDURE: The appropriate CPT procedure codes are used to submit charges for surgical debridement and dressings. Include the location of the debridement and the size, in centimeters, of the area debrided in the description field.

A-235 EYE CARE

Physicians may provide eye care and treatment. Services which may be provided include:

1) those required to determine the presence of disease and whether treatment is indicated;
2) essential medical and surgical treatment; and
3) prescribing and dispensing eyeglasses and other optical materials.

A-235.1 MEDICAL AND SURGICAL DIAGNOSTIC AND TREATMENT SERVICES

Provisions of Topics A-222, A-229, and A-280 regarding office and hospital services apply when eye care is provided.

Ophthalmological diagnostic and treatment procedures are listed in the CPT. Procedures described by codes 92002 through 92287 (except 92070) are covered in the program. Reimbursement will not be made for procedure code 92070 or for procedure codes 92310 through 92396. Please bill using Department codes listed in Appendix A-20, Optical Materials/Service Procedure Codes and Maximum Rates.

A-235.2 PROVISION OF EYEGLASSES AND OPTICAL MATERIALS

This service is not covered for recipients of Transitional Assistance or Child and Family Assistance (category 07), unless specifically requested and individually approved by the Department. In such instances, the recipient will have written authorization from the Department to present to the physician.

Eyeglasses are a covered service only for children through age 20. The only exception to this policy is an adult who undergoes cataract surgery. In that instance, the Department covers the first eyeglasses supplied following the surgery.

All lenses and frames are to be obtained from the Department of Corrections (DOC) laboratory at Dixon Correctional Facility. Reimbursement for the lenses and frames will be made by the Department directly to DOC.

If the physician does not dispense, he/she is to give the necessary prescription to the recipient to take to a participating optometrist of the recipient's choice.

The physician is to dispense or prescribe in accordance with the procedures and requirements found in the Handbook for Optometrists. This handbook may be obtained from:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

A-240 **MATERNAL AND CHILD HEALTH PROGRAM**

The Maternal and Child Health Program is a primary health care program coupled with case management services for Medical Assistance enrolled pregnant women and children. The program is designed to ensure access to quality health care services.

The Maternal and Child Health Program is designed to increase provider participation through special incentives for providers for certain services provided to pregnant women and children through age 20. These include increased payment rates for selected services and expedited payment.

To participate in the program, providers must meet the following requirements:

- maintain hospital admitting privileges;
- maintain delivery privileges if providing care to pregnant women;
- be enrolled and in good standing with the Medical Assistance Program; and
- complete a Maternal and Child Health Primary Care Provider Agreement, or have been enrolled as a provider under the Healthy Moms/Healthy Kids Program, in which they agree to:
  - provide periodic health screenings (EPSDT), including age appropriate immunizations, and primary pediatric care as needed for children served in their practice, consistent with guidelines published by the American Academy of Pediatrics or the American Academy of Family Physicians;
  - provide obstetrical care and delivery services as appropriate for pregnant women served through their practice, consistent with guidelines published by the American College of Obstetricians and Gynecologists or the American Academy of Family Physicians;
  - provide risk assessments for pregnant women and/or children;
  - provide medical care coordination including arranging for diagnostic consultation and specialty care as needed;
  - communicate with the case management entity; and
  - maintain 24-hour telephone coverage for assessment and consultation.

  Under the Maternal and Child Health Program the Department agrees to:

  - Pay enhanced rates for prenatal risk assessment, which includes substance abuse information;
  - Pay enhanced rates for delivery services;
  - Pay enhanced rates for primary care office visits and screening services provided to children;

- Upon request of medical providers, furnish client eligibility and profiles of prior services reimbursed by the Department;

The Maternal and Child Health Program includes a case management component which is in place statewide. Under the case management component, administered by the Department of Public Health, pregnant women and infants under the age of 12 months are provided with case management services by a community-based case management agency that is responsible for assisting the client in accessing health care and support services necessary to comply with their physicians' recommendations. Such case management services are provided through age five years for wards of the Department of Children and Family Services (DCFS).

To participate in the MCH Program, the physician must sign a Maternal and Child Health Provider Agreement, in addition to being enrolled as a Medical Assistance provider. The MCH agreement can be obtained through:

Provider Participation Unit
Illinois Department of Public Aid
Post Office Box 19114
Springfield, Illinois 62794-9114

A-250 FAMILY PLANNING SERVICES

Services and supplies for the purpose of family planning are covered regardless of sex or marital status. An annual physical examination of the female age 12 - 55 for family planning purposes (Department generated code W7454) should include breast examination, pelvic examination, and Pap smear. Contraceptive supplies may be dispensed, prescribed or ordered. Prescriptions for birth control pills, same drug, strength and daily dosage quantity, may be refilled as prescribed by the physician for up to one year. Prescriptions for condoms and spermatocides may also be refilled as prescribed by the physician for up to one year.

The Norplant Contraceptive System is a covered item and may be obtained from a local pharmacy or acquired via Walgreens Healthcare Plus. A physician prescribing the Norplant Contraceptive System may do so by providing the physician's name and provider number, and the patient's name and recipient identification number (RIN) to the distributor:

Walgreens Healthcare Plus
toll free 1-800-345-1036 or
fax number 1-800-332-9581.

Physicians may utilize this program in two ways:

- Order the Norplant kit for a particular client and implant after the kit is received, or;
- Utilize a kit personally purchased and replace with a kit ordered via the above described method.

Walgreens Healthcare Plus will verify client eligibility. Upon verification of eligibility, the Norplant will be shipped to the provider. The turnaround time is approximately three days. Walgreens Healthcare Plus will bill the Department for the Norplant System. The physician is to bill the appropriate CPT code for the insertion of the implant.

PROCEDURE: When charges are made for family planning services, complete Field 23B on Form DPA 2360 showing one all-inclusive charge for the office visit and physician's services provided for family planning purposes.

When submitting a charge for the office visit, and an intrauterine device or Norplant is not inserted, enter the Department generated code for Family Planning Services Office Visit (W7454). (See Appendix A-13.)

When billing for the insertion of an intrauterine device (IUD), use the appropriate CPT procedure code. When charges are submitted for the insertion of the IUD, do not submit a separate charge for an office visit. If a charge is made for the IUD, enter the drug item code for the IUD in 24C.

When billing for the insertion of a Norplant Contraceptive System, use the appropriate CPT procedure code. A separate charge for the Norplant device may be made if it is provided by the physician and not acquired from Walgreens Healthcare Plus. Enter the correct drug item code for Norplant (00082564) in Field 24C.

The Department will reimburse for the early removal of a Norplant device only when the client cannot medically tolerate this method of birth control. The physician should remove the implant and bill the Department using the appropriate CPT code for the removal of the implanted contraceptive device.

When DEPO PROVERA (INJECTABLE CONTRACEPTIVE) is used as a contraceptive, bill with the eight digit drug item number, 00090746 code in Field 24C.

An additional charge may be made for a Pap smear only if the laboratory examination is performed in the physician's own office laboratory.

Services provided to the client during the billing period covered by the invoice which are not related to family planning services must be billed on a separate invoice.

A-260 CONSULTATIONS

A-260.1 GENERAL INFORMATION

A consultation is the service rendered by a physician, at the request of another physician, with respect to the diagnosis and/or treatment of any particular illness or condition involving a client, with the consultant not assuming direct care of the client. The consulting physician is usually a specialist in a different field of medicine than the attending physician.

For payment purposes, a consultation is considered the entire package of physician services required to arrive at a decision and/or recommendation regarding a patient's condition and plan of treatment. A written report from the consulting physician to the requesting physician is to be included in the medical record.

When the consultant bills for only one follow-up hospital visit, the specific diagnosis code which necessitated the follow-up visit must be shown on the Form DPA 2360. When the consultant bills for more than one follow-up visit after the initial consultation, copies of the consultation report and the Hospital Discharge Summary must be attached to the Invoice. Use the appropriate subsequent hospital visit code or follow-up consultation code.

No reimbursement will be made for multiple consultations by physicians of different specialties unless the need is substantiated by the client's physical condition or complications.

If a charge is submitted for a repeat **initial** consultation for a single recipient, the diagnosis pertinent to that service must be shown on the Form DPA 2360. Repeat initial consultations within a six (6) month period are not allowed for the same diagnosis/condition.

Do not submit charges for a consultation when a patient has been referred to another practitioner for treatment. See Topic A-220.1 Referral (Transferred Patient).

Payment is allowed for confirmatory consultations in accordance with CPT guidelines. However, the confirmatory consultation will not be allowed if the physician who provides the consultation is also the surgeon for the treatment under consideration.

A psychiatric consultation includes psychiatric history, determination of mental status, diagnosis, and conference with the primary physician. Use procedure code W7460 when charges are submitted for a psychiatric consultation. CPT procedure codes are not to be used.

When the consulting physician assumes responsibility for the continuing care of the client, any subsequent services should be billed in the role of the attending physician using the appropriate procedure code(s).

If care of the patient is not transferred, but the consultant must provide follow-up care, the Department considers this to be concurrent care. (See Topic A-284.2)

Charges are not to be billed to the Department for a consultation, a medical opinion or a report which is requested by other parties or agencies.

A-260.1 **GENERAL INFORMATION** (Continued)

A pre-surgical examination by the operating surgeon or anesthesiologist is considered an essential element of the surgical procedure and is not reimbursable as a consultation.

Exceptions:

- emergency admissions,
- complications of an emergency nature, or
- a traumatic condition.

Verify the exception by attaching a copy of the Emergency Room report, consultation report, and/or the admission report to the Health Insurance Claim Form DPA 2360.

Except when billing for psychiatric consultation, show the appropriate CPT procedure code based on the level of service provided.

PROCEDURE: Use the appropriate procedure codes from CPT to identify a charge for a consultation. (NOTE: These codes are not used for Referrals as defined in Topic A-220.1)

Complete Field 19 of the DPA 2360 (Health Insurance Claim Form) showing the name and identifying number of the requesting practitioner. See Appendix A-1 for an explanation of the required entries.

Documentation

For the hospitalized patient, a copy of the consultation report must be part of the patient's hospital record. The attending physician's notes are to show that a consultation was requested and the reason it was requested.

A written consultation report is part of the client's medical record in both the consulting and requesting physician's records.

A separate report by the consulting and requesting physician need not be duplicated where common records are maintained by the physicians.

A-260.2 **TELEMEDICINE**

The Department includes coverage for selected telemedicine services. The Department's definition of this service is as follows:

A-260.2 **TELEMEDICINE** (Continued)

> Telemedicine is the real time or near real time two-way transfer of medical data and information between places of lesser and greater medical capability and expertise, for the purpose of patient evaluation and treatment. Medical data exchanged can take the form of multiple formats; text, graphics, still images, audio, and video. The information or data exchanged can occur in real time (synchronous) through interactive video or multimedia collaborative environments or in near real time (asynchronous) through so-called "store and forward" applications.

When speaking of the site where the client is located, the Department refers to that location as the Spoke Site. The site where the telemedicine consultant is located is the Hub Site.

The Department will reimburse one provider at the Spoke Site and one or more providers at the Hub Site depending on medical necessity. The services must be provided in the hospital emergency room or hospital outpatient setting for emergent and non-emergent situations.

- The televideo consult must be provided by a physician located in the hospital outpatient or emergency room setting at the Hub Site.

- The consulting physician must meet the requirements of Illinois law covering consultations.

- Except in emergencies, the consultation must be requested by the patient's attending physician and a request for the consultation must be documented in the patient's medical record.

- The Spoke Site ordering physician must be requesting the opinion or advice of another physician at the Hub Site regarding the evaluation or management of a patient with a specific medical illness and/or injury. The consulting physician at the Hub Site must bill for the consultation services using the appropriate **Hub Site** telemedicine "W" code.

- A physician or other medical personnel such as a physician assistant, nurse practitioner, or licensed nurse, operating under written protocol established by a physician, must be present with the patient during the performance of the telemedicine consultation. It may be necessary for that person to perform portions of an examination such as palpation or visualization of a body orifice (such as the ear canal) which are necessary for the consulting physician to render a decision about the patient's care management. The services provided must be billed using the appropriate **Spoke Site** telemedicine "W" code.

- The consultant's findings and recommendations must be documented in writing in the format normally used for recording consultations in medical records, and included in the patient's medical record at the Spoke Site. The consultant's report may be faxed from the Hub to the Spoke Site.

A-260.2 **TELEMEDICINE** (Continued)

- The video teleconsultation system must, at a minimum, have the capability of allowing the consulting physician to examine the patient sufficiently to allow proper diagnosis of the involved body system. The system must also be capable of transmitting clearly audible heart tones and lung sounds as well as clear video images of the patient and any diagnostic tools such as radiographs.

- Appropriate steps must be taken by the Hub and Spoke Site staff to assure patient confidentiality, based on technical advances.

PROCEDURE: The Department has established "W" codes for use in billing telemedicine services. There are codes specific to Spoke Site and Hub Site providers. Definitions of these codes correspond to Evaluation and Management codes found in the CPT but are to be used exclusively for telemedicine services. The "W" codes, along with the comparable CPT codes and their definitions, are as follows:

FOR SPOKE SITE PROVIDERS

Assigned Department W Codes	**W Code Definition**	**Equivalent CPT Code**
W7470	Telemedicine outpatient visit for the evaluation and management of a new patient, which requires these three key components: - a problem focused history; - a problem focused examination; and - straightforward medical decision making.	***99201***
W7471	Telemedicine outpatient visit for the evaluation and management of a new patient, which requires these three key components: - an expanded problem focused history; - an expanded problem focused examination; and - straightforward medical decision making.	***99202***

A-260.2 **TELEMEDICINE** (Continued)

Assigned Department W Codes	W Code Definition	Equivalent CPT Code
W7472	Telemedicine outpatient visit for the evaluation and management of a new patient, which requires these three key components: C a detailed history; C a detailed examination; and C medical decision making of low complexity.	***99203***
W7473	Telemedicine outpatient visit for the evaluation and management of a new patient, which requires these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of moderate complexity.	***99204***
W7474	Telemedicine outpatient visit for the evaluation and management of a new patient, which requires these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of high complexity.	***99205***
W7475	Telemedicine outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: C a problem focused history; C a problem focused examination; C straightforward medical decision making.	***99212***

A-260.2 **TELEMEDICINE** (Continued)

Assigned Department W Codes	W Code Definition	Equivalent CPT Code
W7476	Telemedicine outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: C an expanded problem focused history; C an expanded problem focused examination; C medical decision making of low complexity.	***99213***
W7477	Telemedicine outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: C a detailed history; C a detailed examination; and C medical decision making of moderate complexity.	***99214***
W7478	Telemedicine outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of high complexity.	***99215***
W7479	Telemedicine emergency department visit for the evaluation and management of a patient, which requires these three key components: C a problem focused history; C a problem focused examination; and C straightforward medical decision making.	***99281***

A-260.2 **TELEMEDICINE** (Continued)

Assigned Department W Codes	W Code Definition	Equivalent CPT Code
W7480	Telemedicine emergency department visit for the evaluation and management of a patient, which requires these three key components: C an expanded problem focused history; C an expanded problem focused examination; and C medical decision making of low complexity.	***99282***
W7481	Telemedicine emergency department visit for the evaluation and management of a patient, which requires these three key components: C an expanded problem focused history; C an expanded problem focused examination; and C medical decision making of moderate complexity.	***99283***
W7482	Telemedicine emergency department visit for the evaluation and management of a patient, which requires these three key components: C a detailed history; C a detailed examination; and C medical decision making of moderate complexity.	***99284***
W7483	Telemedicine emergency department visit for the evaluation and management of a patient, which requires these three key components within the constraints imposed by the urgency of the patient's clinical condition and mental status: C a comprehensive history; C a comprehensive examination; C and medical decision making of high complexity.	***99285***

FOR HUB SITE PROVIDERS

Assigned Department W Codes	W Code Definition	Equivalent CPT Code
W7484	Telemedicine outpatient/emergency department consultation for a new or established patient, which requires these three key components: C a problem focused history; C a problem focused examination; and C straightforward medical decision making.	***99241***
W7485	Telemedicine outpatient/emergency department consultation for a new or established patient, which requires these three key components: C an expanded problem focused history; C an expanded problem focused examination; and C straightforward medical decision making.	***99242***
W7486	Telemedicine outpatient/emergency department consultation for a new or established patient, which requires these three key components: C a detailed history; C a detailed examination; and C medical decision making of low complexity.	***99243***
W7487	Telemedicine outpatient/emergency department consultation for a new or established patient, which requires these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of moderate complexity.	***99244***

A-260.2 **TELEMEDICINE** (Continued)

Assigned Department W Codes	W Code Definition	Equivalent CPT Code
W7488	Telemedicine outpatient/emergency department consultation for a new or established patient, which requires these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of high complexity.	***99245***
W7489	Telemedicine confirmatory consultation for a new or established patient, which requires these three key components: C a problem focused history; C a problem focused examination; and C straightforward medical decision making.	***99271***
W7490	Telemedicine confirmatory consultation for a new or established patient, which requires these three key components: C an expanded problem focused history; C an expanded problem focused examination; and C straightforward medical decision making.	***99272***
W7491	Telemedicine confirmatory consultation for a new or established patient, which requires these three key components: C a detailed history; C a detailed examination; and C medical decision making of low complexity.	***99273***
W7492	Telemedicine confirmatory consultation for a patient, which requires these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of moderate complexity.	***99274***

A-260.2 **TELEMEDICINE** (Continued)

Assigned Department W Codes	W Code Definition	Equivalent CPT Code
W7493	Telemedicine confirmatory consultation for a patient, which requires these three key components: C a comprehensive history; C a comprehensive examination; and C medical decision making of high complexity.	***99275***

A-270 HOME AND LONG TERM CARE FACILITY SERVICES

A physician may provide essential services to a client in the client's place of residence (private home or long term care facility) when the client is physically unable to go to the physician's office.

Charges may be made for a home visit and for any procedures performed by the physician at the time of the visit, in accordance with policy applicable to office services (see Topic A-220), and within the limitations and requirements specified in Topic A-270.1 for services in long term care facilities.

PROCEDURE: CPT procedure codes are to be used as appropriate for the type patient (new or established) level of service and location of services, i.e., home, long term care facility, or sheltered care and other custodial facilities.

Reimbursement is standardized for home and long term care facility services.

When more than one client in a home or in a facility needs and is provided services at the time of a visit, the visits to all additional clients are considered to be coincidental visits.

PROCEDURE: Coincidental visit charges are to be reported by procedure code W7456 in a private home, code W7431 in a licensed long term care facility or W7457 in a sheltered care or other custodial facility.

When it is the physician's usual and customary practice to charge for mileage to see patients at home, charges may be made for mileage from the city limits of the town in which the physician practices to the home, unless subsequently specified otherwise. Only one mileage charge may be made regardless of the number of clients seen at the time of the home visit.

PROCEDURE: Procedure code W7458 is to be used to identify charges for mileage. The total number of miles one way must be specified in the Days/Units field of the Service Section being completed for the mileage charge. The destination, e.g., long term care facility, etc., is to be entered in Field 21 of Form DPA 2360.

A-270.1 LONG TERM CARE FACILITY LIMITATIONS AND REQUIREMENTS

The admission of a client to a long term care facility must have prior approval of the local public assistance office. Approval for admission is given only when a client requires a level of care provided by the facility and when adequate alternate arrangements cannot be made for home or community based care.

When the physician continues to serve as the attending physician to patients after they enter a long term care facility, or accepts as new patients persons who reside in a long term care facility, the physician is expected to provide, as a minimum, those physician's services which are required by Federal regulations and by the Illinois Department of Public Health Facilities Code Rules and Regulations to be provided in Medical Assistance certified facilities.

All services provided to a client in long term care facilities by a physician are to be documented in the client's chart maintained in the facility.

A-270.1 **LONG TERM CARE FACILITY LIMITATIONS AND REQUIREMENTS** (Continued)

Charges are not to be submitted for routine, non-individually essential visits to clients in long term care facilities. Visits made to clients eligible for Medicare benefits will be disallowed if determined not medically necessary by Medicare.

Payment cannot be made for screening and/or preventive services or for routine or periodic examinations. Initial certification and periodic recertification by the attending physician of a client's need for long term care services are required by Federal regulations; consequently, if the physician needs to make a special visit to meet these requirements, because of not having seen the client since the physician's initial certification or last recertification of need for long term care, such a visit will be allowed as an essential brief service visit for an established patient.

Except for emergency services provided when the attending physician is not available, a physician other than the attending physician of record may not charge for services to a client in a long term care facility unless the attending physician has made referral with the client's knowledge and permission.

No charges may be made for services provided clients in a long term care facility by a physician who derives a direct or indirect profit from total or partial ownership (or from other types of financial investment for profit) of such facility, except:

a) for emergency services provided for acute illness; or
b) when there is unavailability of essential treatment facilities in the vicinity for short-term care pending transfer; or
c) when there is not a comparable facility in the area.

Physicians who derive direct or indirect profit from total or partial ownership may not charge for mileage.

Charges may not be made for services to clients in a long term care facility by a physician who receives reimbursement from the facility for direct patient care services.

On an individual basis, a physician may refer a client in a long term care facility for covered services of another provider type. However, inasmuch as screening services are not provided in the Medical Assistance program, such referrals are to be made only when there is an identifiable medical need of the client for the specific type service. The provider to whom referral is made is responsible for obtaining any necessary authorization from the Department prior to providing the service.

In all instances, clients must be offered without prejudice the freedom of choice of facilities.

A-280 HOSPITAL SERVICES

Essential physician's services provided on an inpatient or outpatient hospital basis are covered. A physician may charge only for those services the physician personally provides to a hospitalized client. A physician may not charge for services provided by hospital staff, even if the services are ordered by the physician.

A physician may not charge for mileage incurred while caring for clients in hospitals.

A-281 OUTPATIENT SERVICES

A-281.1 REFERRED SERVICES

A physician may refer clients for essential services such as laboratory tests, x-ray examinations, etc., which are provided by a hospital on an outpatient basis. Charge may not be made by the physician for referral or for the services not personally provided by the physician.

A-281.2 EMERGENCY SERVICES

Emergency services are those services which are for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, possessing an average knowledge of medicine and health could reasonably expect that the absence of immediate attention would result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

If the patient goes to the hospital for emergency care, the hospital's Emergency Department must provide the initial service; and the initial service must be directed or coordinated by the Emergency Department physician.

Payment for emergency services may be made for either the visit or for specific procedures performed, such as suturing, lavage, application of cast, etc.

The emergency room physician may not submit separate charges for the interpretation of x-rays or EKGs.

PROCEDURE: When the physician is assigned to the emergency department or is in the emergency room because of other activity there, use the appropriate CPT procedure code or Evaluation/Management (E/M) code for Emergency Department services, with place of service "E". The appropriate emergency definer code from Appendix A-12 is to be entered in Field 10B, Other, on Form DPA 2360. The physician must bill using his/her own name and provider number.

A hospital may bill for a visit or procedure for only one **salaried** physician's emergency level I or II services in the Emergency Department (see Outpatient Reform Action Notice dated July 1, 1998 for details). The hospital must bill on the DPA 2360 using its "400" series provider number and should also bill on a UB-92 for that patient for the same date of service. The DPA 2360 claim must include that physician's name and identification number in Field 19, place of service "E", and the appropriate code from Appendix A-12 in Field 10B, Other.

Under no circumstances may the physician's services be billed by both the physician and the hospital.

If a client receives only non-emergency/screening services in the Emergency Department, the hospital may select the most appropriate billing mechanism on a patient-by-patient basis. No more than one of the options may be billed for any one outpatient visit.

A-281.2 **EMERGENCY SERVICES** (continued)

Option 1 is for the hospital to bill for a screening fee only. If Option 1 is being used, the hospital may bill on the UB-92. This is permissible even if a non-salaried Emergency Department physician also bills. The screening fee payment is all-inclusive and, therefore, the hospital may NOT bill for any professional or technical components of the services provided in the Emergency Department.

Option 2 is to bill fee-for-service for professional and technical component services only. If the hospital is billing fee-for-service only, the hospital may bill on the DPA 2360 for ALL services provided, including the professional and technical components of the services, using the hospital's "400" number.

A-281.3 **NON-EMERGENCY SERVICES**

When a physician sees a patient in the outpatient department of a hospital on a nonemergency basis, for the convenience of either the patient or the physician, the visit is considered the same as an office visit.

PROCEDURE: If a charge is being submitted for the visit, the appropriate CPT Evaluation Management (E/M) procedure code is to be entered on the billing form. The place of service must be "2", Outpatient Hospital, or "3", Doctor's Office. Charges are to be made for procedures as indicated for office services.

A-281.4 **PROLONGED PHYSICIAN SERVICES**

Payment is allowed for prolonged physician service (detention) with direct (face to face) patient contact when the medical condition of the client necessitates such care. The service must be provided in either the Outpatient Hospital or Emergency Room or Inpatient Hospital setting. No payment is allowed for prolonged physician service in the physician's office.

A narrative explanation of the service must be submitted with the claim and must include: 1) the reason for the prolonged service, i.e., the medical condition(s); 2) exact total time involved; and 3) services rendered during that time period. The amount of time billed should not include time spent performing procedures, and must be only the amount of time the physician was involved in face-to-face contact with the client. If charges are submitted for one or more procedures by the same physician who is billing for prolonged service, the narrative must state that the amount of time shown is separate from the time required for the procedure(s).

PROCEDURE: The appropriate CPT code for outpatient or inpatient prolonged service is to be shown for the first hour and the total minutes should be shown in the space for service description (Field 24C). All the additional time should be shown with a second charge and the appropriate CPT code for outpatient or inpatient prolonged services for each additional 30 minutes. The time must again be specified in Field 24C.

A-281.4 **PROLONGED PHYSICIAN SERVICES** (continued)

NOTE: Do not bill for each 30 minutes with a separate charge, as the same code cannot be billed more than once for the same date, same client. Do not use the days/units field to show the time.

EXAMPLE: A total of 3 ½ hours for prolonged physician service is to be billed with one charge and the appropriate code for the first hour. Then a second charge is to be billed using the procedure code for each additional 30 minutes but with the charge being for all of the remaining 2 ½ hours.

The CPT codes which specify "Outpatient" are also to be used for the Emergency Room.

A-281.5 **HOSPITAL OBSERVATION CARE**

A physician may charge for hospital observation care by using CPT procedure codes and in accordance with CPT guidelines. Other evaluation and management services, e.g., office visit, emergency room visit, etc., on the same day may not be reported/billed separately.

If the client is admitted to the hospital on the same service date as the observation, a charge may be submitted only for the initial inpatient visit. No payment will be made for the observation services.

Observation care may not be billed for periods of post-operative recovery from surgery, e.g., outpatient procedures.

Payment will not be allowed for observation care for consecutive dates of service. Also, only one observation code may be billed. The code for observation care “discharge” is not a covered service.

Payment is not allowed for observation care for obstetrical cases in labor if the client is admitted to the hospital from the observation area and delivers during that hospital stay.

A-282 INPATIENT SERVICES

A physician may admit a client for essential inpatient hospital services in connection with covered treatment of an illness or injury. The physician should assure that the patient meets the established inpatient criteria.

Billing statements submitted for hospital visits are to show the appropriate CPT procedure code which designates the level of care provided.

A-282.1 UTILIZATION REVIEW

The medical need for hospital admission and the length of the hospitalization are monitored and controlled by the Hospital Utilization Review Committee (HURC).

Medical reviews may be conducted by the Department or its designated agent. Medical review shall be used to ensure the appropriateness and medical necessity of selected inpatient stays. Medical review may be completed for medical necessity of admission, length of stay, and/or quality of care. The Department or its agent may use Severity of Illness/Intensity of Service (SI/IS) or other review criteria to review all or a portion of inpatient stays. If there is any change in the review criteria, the Department will give providers a minimum of thirty (30) days written notice before the change is implemented.

The Department does require prepayment review of various types of hospital care, e.g., psychiatric care. The Department may use prepayment, post payment, and/or concurrent or other review processes for inpatient stays. The Department will provide a reconsideration process when a denial decision has been reached on all or a part of an inpatient stay.

The physician will be notified by the representative of the HURC when a determination has been made that continued inpatient hospitalization is not essential. Charges for physicians' services provided during an unauthorized period of hospitalization are not to be submitted for payment.

If a physician questions a determination that continued hospitalization is non-essential, the physician should contact the Chairman of the HURC.

Prior to seeking reimbursement of the hospital stay, the HURC is responsible for certifying that the patient's care was medically necessary and met established inpatient criteria.

A-283 **SURGICAL SERVICES**

Covered surgical procedures which are medically necessary are allowable.

When a physician recommends non-emergency surgery, the patient may wish to obtain a second opinion from another physician regarding the need for such surgery. Payment can be made by the Department to a qualified physician who provides a second opinion for a client.

The charge made for a major operative procedure includes the presurgical examination and complete postoperative care including postoperative office visits and customary wound dressing for a minimum period of 30 days.

The Department's allowable surgeon's fee for surgeries relating to burns (debridement, skin grafting, and/or flaps, etc.) includes visits, wound care, dressing changes for a period of only 7 days after the surgical procedure. Separate payment is allowed for visit by the operating surgeon beginning on the eighth day after surgery.

NOTE: Payment is allowed for visits by a physician other than the surgeon any time during the post operative period for burn or transplant cases. The diagnosis code shown must denote the reason for the visit(s).

NOTE: For surgeries other than for burn cases or transplants, a physician other than the surgeon may bill for visits only for condition/diagnoses unrelated to the surgery. A copy of the hospital discharge summary or a narrative explanation of the medical necessity for the care must be submitted with each claim.

NOTE: The Department may request operative reports as necessary in order to determine payment. The report provided to the Department must be a photocopy of the official operative report on file at the hospital. **The date of surgery on the operative report must be the same as the service date shown on the claim. The name of the operating surgeon shown on the operative report must match the name of the billing surgeon.**

NOTE: When billing for multiple procedures and/or very complex surgeries, the physician is to submit an operative report with the claim.

When multiple surgical procedures are performed during the same operative session, payment will be based on the procedures described.

PROCEDURE: Surgical procedures are to be billed using the appropriate CPT code(s). Surgical procedures incidental to the major procedure or those considered a component of the major procedure should not be billed.

The invoice submitted with a surgical charge must be completed with an entry of 2 (Surgeon) in Field 23E (T.O.S.). The appropriate procedure code for the specific surgical procedure is to be entered on the claim in Field 24C.

A-283 **SURGICAL SERVICES** (Continued)

Bilateral surgical procedures must be billed by the surgeon with the specific code for one side and an unlisted code and a second charge for the opposite side, unless the description for the specific code indicates that it is for "bilateral" or "unilateral or bilateral."

PROCEDURE: Enter the correct (specific) code and charge for one side and an "unlisted" code from the same series and a second charge for the opposite side. A brief service description must be shown for the "unlisted" code. The description narrative is to specify the type of procedure and that it was bilateral. Submit an operative report with the claim for unusual and/or complicated surgeries.

Multiple identical surgical procedures must also be billed using a correct code for the first service and an "unlisted" code and a second charge which includes all the additional procedures. Only one code and charge are required if the procedural description for the specific code indicates a certain number or a number range. For the latter, show the number in Field 24C of the claim. Do not use the Days/Units Field.

PROCEDURE: Enter the correct (specific) code for the first procedure, and an "unlisted" code from the same series and a second charge which includes all the additional identical procedures. Enter a brief procedural description which includes the number of additional procedures and submit an operative report with the claim.

NOTE: Modifiers should not be used to report bilateral or multiple procedures.

A-283.1 **ANESTHESIA**

When the anesthesiologist is called to the hospital and is not paid by the hospital or other entity as an employee or independent contractor for this service, the anesthesiologist may bill for these services.

When anesthesia is personally administered by an anesthesiologist who remains immediately available in the operating area during a surgical procedure, the anesthesiologist may submit charges if the cost of the anesthesiologist's services is not included as an expense item in the hospital reimbursable costs and the hospital makes no charge for the services. (If the anesthesiologist is concurrently responsible for the care of more than one anesthetized patient, a claim may be submitted for each patient involved.)

General Anesthesia - When billing for general anesthesia, the anesthesiologist is to submit one charge for all procedures done during a single operative session. Enter Type of Service code "7" in Field 23E of Form DPA 2360. One procedure code which describes a major surgical procedure is to be shown in Field 24C. Enter the appropriate anesthesia modifier (A-G) from Appendix A-14 of this Handbook in the "Modifying Units" box of Field 24C. Enter the total anesthesia administration time (which accounts for all procedures done during the operative session) in Field 24F ("Days/Units") as the total number of minutes of service. This field uses a four-digit format. EXAMPLE: Show one hour and thirty-seven minutes as 0097 "Units".

NOTE: When surgical procedures are performed during separate operative sessions on the same service date, separate charges should be shown for each operative session with the major surgery code, modifier, and total administration time for each session. The Operative Report or Anesthesia record for each operative session must be attached to the claim(s) as documentation that services were provided at different times of the same day.

NOTE: When the general anesthesia administration time billed is eight hours or more (480 minutes or more), the anesthesia record or a narrative explanation signed by the physician must be submitted with the claim.

Payment is **not** routinely allowed for the administration of **general anesthesia** for vaginal deliveries. If general anesthesia is required for a vaginal delivery, the CPT "unlisted" code for maternity care must be used. A description of the service must be shown in Field 24C of the DPA 2360 or on an attachment. An anesthesia record will also be accepted.

Continuous Epidural Anesthesia - When the anesthesiologist administers continuous epidural anesthesia, show one charge for all procedures done during a single operative session. (Enter Type of Service code "7" in Field 23E of Form DPA 2360.) Show CPT code 62279 in Field 24C. When only epidural anesthesia is administered, make no charge for the surgical procedure code. Enter the appropriate anesthesia modifier from Appendix A-14 in the "Modifying Units" box of Field 24C. Enter the total time of epidural administration in Field 24F ("Days/Units") as the total number of minutes of service. This field uses a four-digit format.

NOTE: When the epidural administration time billed for labor and vaginal or Cesarean delivery is twenty-four hours or more (1440 minutes or more), the anesthesia record or a narrative explanation signed by the physician must be submitted with the claim.

If epidural anesthesia is followed by general anesthesia on the same date of service, a second charge should be shown for the general anesthesia with a major surgery procedure code. Show the total administration time for the epidural for code 62279, and the total time for the general anesthesia administration for the major surgery code. **The anesthesia record or a narrative explanation of services must be attached to the claim as documentation that both types of anesthesia were administered on the same date.**

When epidural anesthesia is started during labor and continued during Cesarean Section surgery or vaginal delivery, submit one total charge which includes the total administration time. If the epidural is discontinued and a general anesthetic is administered for the Cesarean Section, two separate charges are to be shown (one for code 62279 with the total time for epidural and one for the specific CPT Cesarean Section code with the total time for the general anesthetic). The anesthesia record or a narrative explanation that both epidural and general anesthesia were administered must be attached to the claim.

A-283.1 **ANESTHESIA** (Continued)

NOTE: CPT code 00857 may be used instead of 62279 when billing for continuous epidural for labor and Cesarean Section. Code 00955 may be used instead of 62279 when billing for continuous epidural for labor and vaginal delivery.

The operating surgeon may charge only for the administration of spinal anesthesia which he/she personally administers.

PROCEDURE: Enter CPT procedure code 62278 in Field 24C of Form DPA 2360 to identify spinal anesthesia administered by the operating surgeon. (Type of Service code "7" is to be entered in Field 23E.) Make no entry in the "Days/Units" Field 24F or the "Modifying Units" Box.

No charges may be made for the preoperative consultation or routine postoperative follow-up care. Payment is allowed for postoperative pain management only for cases of intractable pain, e.g., due to multiple trauma injuries or metastatic cancer.

PROCEDURE: CPT code 62278 is to be used for the epidural catheter insertion on the first day. CPT code 01996 is to be used for subsequent days of pain management. The diagnosis shown must be indicative of medical necessity. A maximum of seven (7) days is allowed. No charge is to be made for routine postoperative pain management.

If an anesthesiologist provides any services other than administering or supervising the administration of anesthesia, the same complete billing procedures routinely used by other physicians for their services must be followed.

In such cases, in addition to the primary diagnosis, it is also required that the secondary diagnosis which necessitates the anesthesiologist's services must be stated.

A-283.11 **Anesthesia Supervision**

When an anesthesiologist has responsibility for the supervision of the administration of anesthesia by a nurse anesthetist or a technician, the anesthesiologist may charge for services if this is the anesthesiologist's usual and customary practice, but only in instances in which the anesthesiologist is not reimbursed by the hospital and the hospital does not include the cost of anesthesia supervision in its reimbursable cost statement.

Independent Certified Registered Nurse Anesthetists (CRNAs) do not require supervision. The Department will not reimburse both an anesthesiologist and a CRNA for the same procedure.

A-283 **SURGICAL SERVICES** (Continued)

A-283.1 **ANESTHESIA** (Continued)

A-283.12 **Anesthesia Standby**

An anesthesiologist may submit a charge for "standby" only when a surgical procedure has been scheduled and is canceled due to the patient's condition.

PROCEDURE: Enter Type of Service (T.O.S.) Code 7 in Field 23E of Form DPA 2360. Enter the "unlisted" code for the body system/area related to the scheduled surgery. Enter "Standby for surgery canceled due to (specify reason)". Enter the amount of time required for the standby in Field 24F, Days/Units, in four digit minute format. **NO MODIFIER IS TO BE SHOWN AND THE "UNLISTED" PROCEDURE CODE MUST BE USED.**

NOTE: Standby is not allowed for situations where surgery may or may not be necessary, e.g., an attempted vaginal delivery which may result in a Cesarean delivery due to complications, etc.

A-283.2 **CO-SURGEON /SURGICAL ASSISTANCE**

A-283.21 **Co-surgeon**

When two surgeons of equal competence participate in an operation on a basis of other than surgeon and assistant surgeon, payment is based upon the procedure(s) accomplished and will be divided equally between the two surgeons.

PROCEDURE: Enter the appropriate procedure code(s) for the specific surgical procedure(s) on the claim. Each surgeon billing must submit a copy of the operative report with Form DPA 2360 in the preaddressed mailing envelope, Form DPA 2248, Special Handling Envelope. If each surgeon dictates his/her own operative report, both versions must be provided. Enter the code "S" in Field 23E (T.O.S). Enter the following statement in the narrative portion of Field 24C, "Co-surgeon with Dr. (name of co-surgeon)."

A-283.22 **Surgical Assistance**

Surgical assistance is a covered service only when provided for major or complex surgical procedures.

If the presence of a surgical assistant is required by hospital bylaws on other than a major surgical procedure, reimbursement for such service will be considered only if the bill is accompanied by a photocopy of the hospital's bylaws.

Payment is made for only one surgical assistant. The physician who serves as the assistant surgeon is to submit charges to the Department.

A-283 **SURGICAL SERVICES** (Continued)

A-283.2 **CO-SURGEON /SURGICAL ASSISTANCE** (Continued)

A-283.22 **Surgical Assistance** (Continued)

PROCEDURE: Enter the appropriate procedure code for the major surgical procedure on Form DPA 2360. **Field 23E (T.O.S.) of Form DPA 2360 must show code "8"** to denote that the charge is as an Assistant Surgeon. Complete the "Days/Units" field of the service section showing the time required to assist at the surgery. Enter the actual time in 4-digit minute format, e.g., the entry for 1 hour and 10 minutes is "0070". **DO NOT ENTER A MODIFIER.**

When the surgical assistance time billed is eight hours or more (480 minutes or more), documentation, e.g., a copy of the operating room record which shows the time surgery began and ended, must be submitted with the DPA 2360 for reimbursement consideration. The report provided must specify the amount of time required for the surgery. A narrative signed by the physician verifying the amount of time is also acceptable.

A-284 HOSPITAL VISITS

The admitting physician may charge for an admission initial workup of the client only if this has not previously been provided in the physician's office or on an outpatient basis prior to the scheduling of the hospital admission. The initial workup includes comprehensive history, physical examination, and initiation of the diagnostic and treatment program. Only one attending/admitting physician will be paid for the initial hospital visit for a single hospital stay.

After the day of admission, one subsequent visit per day may be billed by the attending physician. When the client's condition warrants the services of one or more additional physicians of different specialties, charges are to be submitted as discussed in Section A-284.2, CONCURRENT CARE.

Payment is not allowed for a subsequent visit if the same physician performs/bills for a diagnostic or therapeutic procedure on the same service date.

All visits and services for which charges are made must be documented in the client's hospital record.

A-284.1 CRITICAL CARE SERVICES

When a recipient is placed directly in a critical care unit on the day of admission, the admitting physician is to bill using the appropriate CPT evaluation and management (E/M) code for initial hospital care. Daily subsequent visits by the physician to the critical care unit are to be billed under the appropriate CPT code(s) for critical care. The codes as of 01-01-98 are 99291 and 99292.

The Department's payment policy and billing guidelines for critical care are as follows:

- Payments will be allowed to one physician for a maximum of one and one half hours of critical care daily for up to 10 days per hospital stay for a single recipient. The appropriate CPT code for critical care first hour is to be used when the visit requires one (1) hour or less. (If the total duration of care is less than 30 minutes, the visit should be billed using the appropriate E/M code.) If the visit requires more than one hour, a second charge may be made for the code for "critical care, each additional 30 minutes", if the additional time spent is more than 15 minutes. The second charge is not to be made for time periods of less than 15 additional minutes.

  NOTE: Only one additional 30 minute increment is allowed per day. The Days/Units field of the claim should be left blank when billing for this service. **Please do not use this field to indicate time.** The same physician may bill for both the first hour and the additional 30 minutes, or the two services may be billed by two different physicians. However, payment will be limited to one occurrence of each code per day per recipient.

- While the recipient is in the critical care unit, other physicians, e.g., consultants who make daily visits, must use the appropriate CPT evaluation and management (E/M) codes for subsequent hospital care. These additional physicians must also document the medical necessity for their services by submittal of a copy of the hospital discharge summary with their claim(s). **(See Topic A-284.2, Concurrent Care.)**

A-284 **HOSPITAL VISITS** (Continued)

A-284.1 **CRITICAL CARE SERVICES** (Continued)

NOTE: If payment has already been made for subsequent hospital visit codes to one physician and a different physician bills for critical care for the same date(s), the hospital discharge summary must be provided or the critical care visits will be rejected. To prevent rejection of visits, both the attending and consulting physician should submit a discharge summary and/or narrative explanation to justify the concurrent care.

- Payment is not allowed for postoperative critical care visits for surgical procedures which routinely require critical/intensive care for one or more days. This postoperative time period includes the day of surgery and 30 days after surgery.

- The critical care visit includes the interpretation of diagnostic tests such as blood gases, cardiac output measurements and EKGs. The following procedures are also included in the visit: gastric intubation, temporary transcutaneous pacing, ventilation management and vascular access procedures. Separate payment is not allowed for these services. Refer to the CPT for services included in the critical care visit.

- When the same physician performs a procedure or procedures other than those which are included in the visit, and sees the recipient in the critical/intensive care unit, payment will be made for the procedure or the visit, but not both. The allowable service is the one with the higher State maximum allowable fee.

- The maximum allowable of ten days of critical/intensive care per hospital stay applies whether the service dates are consecutive or intermittent.

NOTE: Individual consideration will be given to charges for more than ten days of critical care when documentation of medical necessity is submitted with the claim(s). This documentation must be in the form of a hospital discharge summary. A narrative explanation may be submitted in addition to the discharge summary. The Department will determine if payment can be made for any additional days based upon this documentation. Rejected services should be rebilled using appropriate CPT evaluation and management codes for subsequent hospital care/visits.

A-284.2 **CONCURRENT CARE**

When a client requires the specialized service(s) of an additional physician(s), either concurrently or intermittently during a period of hospitalization, reimbursement can be made for the services of both the attending and consultant physicians with documentation of medical necessity. Each physician must identify the diagnosis he/she is personally treating.

There must be a clearly identified attending physician, who is responsible for ordering the consultation and approving continuing concurrent care by specialists.

The attending physician must assume sole responsibility for the care of the client as soon as the specific need for consultation and concurrent care is met.

A-284.2 **CONCURRENT CARE** (Continued)

Legible documentation is required for payment for concurrent care. That documentation for hospital care must include all of the following:

- The initial request by the attending physician, with the specific reason for the consultation,
- The consultation report by the specialist, which should include among its recommendations whether concurrent care is required, and for what period. The attending physician must indicate agreement with a recommendation for concurrent care in the medical record,
- A written justification (a copy of the Hospital Discharge Summary) that the services required are beyond the scope of the attending physician. In general, these will be when:
  - the client's condition is severe or complex, or when there is an acute exacerbation or deterioration of the client's condition, or
  - there is a complicated diagnostic regimen required, particularly one requiring the application of specific medical technology typically within a subspecialist domain, or a complicated therapeutic regimen requiring frequent monitoring or changes, or
  - specific expertise of the specialist is required, for example, in infectious disease, oncology or others, or
  - a team approach is required, for example, in trauma care, or
  - general medical care is concurrently required when limited specialists, for example, ophthalmologists or others, admit a client with chronic medical conditions requiring active treatment.

PROCEDURE: The invoice submitted for concurrent care charges must be completed with an entry of "G" in Field 23E (T.O.S.) of DPA 2360 and the appropriate procedure code in Field 24C. Subsequent hospital visit or follow-up inpatient consultation codes may be used for days following the initial consultation. A copy of both the consultation report and the Hospital Discharge Summary must be attached to the invoice when the consultant bills for more than one (1) follow-up visit/consultation.

A-285 SURGERY FOR MORBID OBESITY

This type of surgery is a covered service with case-by-case approval by the Department. Approval is given only in those cases in which obesity is determined to be exogenous in nature with the client having had the benefit of other forms of therapy (dietary, etc.) with no success, and after procedures have been performed to rule out endocrine disorders. Approval is limited to those cases of extreme obesity with morbid complications and is not a covered service for weight reduction or control in general obesity. The responsibility for the determination of cases in which these criteria are met rests with the Department.

PROCEDURE: The surgeon must request approval of payment for surgery for morbid obesity (including revision or restoration of either an ileal or gastric procedure) by submitting Form DPA 1409, Prior Approval Request. (See Appendix A-6 for facsimile of the request form and instructions for completing and mailing.)

In addition, a letter documenting medical necessity, patient history and physical, must be attached to the Form DPA 1409 or may be submitted via FAX to be filed with the telephone prior approval request.

If charges are submitted without having obtained approval of payment, consideration will not be given to reimbursement.

Payment will not be made for bypass or other forms of surgery for morbid obesity performed in conjunction with other abdominal surgery when approval has not been requested and granted.

A-286 VENTILATION MANAGEMENT/PULMONARY TESTING AND THERAPY

Ventilation management is a covered service when provided to a client based upon medical necessity. Initial ventilation care is allowed for inpatient hospital and nursing home settings. Subsequent care is allowed in the patient's home, in addition to inpatient hospital and nursing home.

In addition, charges may be made by the physician who is responsible for the ventilation management.

PROCEDURE: Use the correct CPT code for the initiation of pressure or volume preset ventilators for assisted or controlled breathing first day and subsequent days when completing the Health Insurance Claim Form DPA 2360. Enter a 1, 4 or 7 in Field 23E (T.O.S.) on the DPA 2360, as well as Field 24B (Place of Service).

A subsequent hospital visit (Evaluation Management Codes) is not allowed the same day as ventilation management to the same provider. Another provider may charge for a visit for an unrelated diagnosis.

Ventilation management, initial or subsequent, is not allowed when billed by the anesthesiologist for the day anesthesia is administered for surgery. The provision of adequate ventilation to a recipient is included in the anesthesia administration fee. When care is rendered in the two days immediately preceding or in the two days immediately following a surgical procedure, by the same physician who provides the surgical anesthesia, the services are considered as part of the anesthesia services related to the surgery and separate charges may not be made for the therapy.

Payment is allowed to a physician for the interpretation of pulmonary function tests for inpatients. A physician may not bill for pulmonary treatments other than ventilation management, e.g., IPPB, Inhalation, etc., for hospitalized clients. Charges may be made, however, for daily visits as appropriate.

Use the appropriate procedure code for hospital medical visits when submitting charges for respiratory care therapy. A "1" should be entered in Field 23E (T.O.S.) on the DPA 2360.

A-290 MATERNITY CARE

Use the appropriate office visit code for the level of service provided to bill the initial visit to determine pregnancy. A separate charge may not be submitted for an antepartum care code on the date of the initial visit. Bill each medically necessary subsequent office visit which is related to the pregnancy under the appropriate CPT procedure code for antepartum care. (Code 59420 has been deleted from the CPT, but may be billed.) Use the appropriate CPT procedure code for either vaginal delivery or Cesarean Section to bill the delivery. A charge may be submitted for only one (1) six week postpartum visit per client, per delivery. All maternity care services must be billed with separate codes, dates, and charges. An all-inclusive "global" care package will not be reimbursed.

Medical office visits which occur during the prenatal or postpartum period for conditions other than pregnancy should be billed using the appropriate office visit procedure code for the level of service provided.

Payment for delivery includes admission to the hospital, the admission history and physical, management of labor, vaginal or Cesarean delivery and postpartum hospital care.

Billing for twin births should be done by entering the appropriate delivery code for the first baby and the unlisted procedure code for the second baby. Enter the description “twin” on the DPA 2360 claim form in the description section (Field 24C) and a separate charge for each delivery in Field 24E. The unlisted procedure is hand priced for additional payment. If one baby is delivered vaginally and the other by Cesarean section, bill the correct code for each with separate charges, and attach both delivery reports.

Enhanced rates are available to physicians meeting requirements for enrollment into the Maternal and Child Health Program. Contact the following address for enrollment:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, IL 62794-9114

Emergency room or inpatient hospital visits for complications of pregnancy or other diagnoses/conditions not related to pregnancy should be billed separately using the appropriate visit codes. The diagnosis code(s) shown on the invoice must be pertinent to the condition(s) which necessitated the hospital visit(s). Bill the day of admission to the hospital under the appropriate "subsequent" visit code when the admitting physician has also been providing prenatal care.

Payment is allowed for initiation and/or supervision of internal fetal monitoring during labor only when performed by a consulting physician. This service must be billed with a diagnosis code(s) which reflects medical necessity, e.g., high risk pregnancy. It is not allowed for routine/normal labor/delivery cases or for false labor. The labor must result in delivery, and only one charge per delivery is allowed.

NOTE: Payment may also be made for a vaginal delivery that the physician performs in the patient's home. The appropriate CPT vaginal delivery procedure code is to be used, and Place of Service (POS) on the DPA 2360 is **4**. If the physician bills electronically for in-home delivery, the appropriate National Standard Format is to be used.

A-291 DELIVERY PRIVILEGES

The Department requires that a physician billing for prenatal services have hospital delivery privileges or, if the physician does not have such privileges, then the physician must have a written agreement with a physician or a group of physicians who do have such privileges and who agree to accept referred patients for delivery and hospital care. The agreement further attests that the referring physician will provide patient's medical records to the admitting physician on their mutually agreed upon date of transfer of the patient from the care of the referring physician to the care of the admitting physician, but no later than thirty-six (36) weeks of the gestational period. A copy of a properly executed agreement must be on file and available for inspection at the office of each of the physicians involved in the agreement.

The patient must be informed of the arrangements and, if she concurs with the arrangements, she must be informed as to how to access this care and be provided with all relevant information, including the name(s) of the physician(s) who have agreed to provide delivery and hospital care.

If a physician does not have hospital delivery privileges or does not have an agreement on file with the Department showing that the physician has made arrangements for the transfer of obstetrical patients to a physician who does have such privileges, the physician may not bill the Department for prenatal care.

A-291.1 STANDARDS OF CARE

The course of pregnancy is a dynamic process and a woman's risk status can change in either direction at any point during the pregnancy. This necessitates frequent assessments of a pregnant woman's risk in order to initiate the type and range of services that will ensure the best outcome. Physicians are expected to meet the American College of Obstetricians and Gynecologists (ACOG) standards for the provision of prenatal services and risk assessment.

A-291.2 HOME UTERINE MONITORING

In an effort to prevent premature delivery by the high-risk pregnant woman, the Department provides reimbursement for home uterine monitoring as a Medical Assistance covered service in those cases where the woman is hospitalized and is being discharged on tocolytic drugs. An all-inclusive daily rate is paid directly to the supplier of the monitoring device.

A-292 NEWBORN CARE

The initial examination and routine follow-up hospital care of the newborn child is considered a part of the delivery service and may not be billed by the delivering physician as a separate charge. Charges for the initial examination and care of the newborn may be submitted only in those instances in which the hospital requires pediatrician involvement in all newborn cases, or the obstetrician's practice is limited to exclude newborn care.

Bill normal newborn care with **one all-inclusive charge** under CPT code 99431 or 99435. The care includes history and examination of the infant, daily hospital visits, initiation of diagnostic and treatment programs, preparation of hospital records, routine nursery care supervision, and discussion(s) with the mother.

A separate charge may be submitted for the physician's attendance at a Cesarean or **high risk** vaginal delivery (code 99440 or 99436).

Any child born to a client is automatically eligible for medical assistance for one year as long as the mother remains eligible for assistance and the child lives with her. The mother is not required to make a formal application for the child to be added to her case. Consequently, the child's name may not appear on the mother's MediPlan Card as an eligible member of the assistance case until a later date. Medical providers may request that a newborn be added to Medical Assistance case by contacting the local public assistance office and providing them with the following information:

- The mother's name and case number
- The name of the newborn
- The birth date of the newborn
- The sex of the newborn

Special billing instructions are to be followed when submitting charges only for normal newborn care services provided when the name of the eligible child does not appear on the MediPlan Card:

PROCEDURE: Use CPT procedure code 99431 or 99435 when billing for normal newborn care. Complete the claim in accordance with instructions found in Appendix A-1 except for the following fields:

- Field 1 Enter "Baby Girl" or "Baby Boy" as appropriate.
- Field 2 Enter the child's birthdate.
- Field 8 Enter the mother's recipient identification number.
- Field 24 Complete the service date box to show the first date newborn care was provided.

The claim may be mailed with routine invoices.

When the medical condition of the newborn necessitates extended care for conditions such as extreme prematurity, cardiac and/or respiratory problems, anomalies, etc., the initial hospital care, subsequent visits and diagnostic/therapeutic procedures should be billed as for other hospitalized patients (except for newborns in the Neonatal Intensive Care Unit).

A-292 **NEWBORN CARE** (Continued)

If the newborn's condition(s) requires the specialized services of more than one physician, i.e., an attending physician and a consultant, each physician must identify the diagnosis/condition being treated and the consultant must submit copies of the Consultation Report and the Hospital Discharge Summary. (See Topic A-260, Consultations, and A-284.2 Concurrent Care).

The procedure code for "normal newborn care" should not be billed in conjunction with charges for other hospital visit codes for extended care as described above.

If the newborn is not in the Neonatal Intensive Care Unit and a venous or arterial catheter is inserted by the physician for diagnosis and/or therapy, charges should be submitted only for the initial insertion and any necessary reinsertion procedures. Charges should not be made for procedures such as venous or arterial catheterization/cutdown on a daily basis.

A-292.1 **NEONATAL INTENSIVE CARE**

CPT codes for Neonatal Intensive Care Unit (NICU) visits are to be billed for critically ill newborns, age birth through two months, who are in a neonatal intensive care unit for critically ill newborns. Payment is allowed for only one NICU visit code per day, per client. The initial NICU visit code may be billed only one time per client. For the second level of NICU care (for the critically ill and unstable neonate/infant), payment is generally allowed for a maximum of twenty (20) days. Payment may be made for second level NICU care in excess of twenty (20) days if the billing includes documentation of the medical necessity, i.e., provision of a narrative explanation of the neonate/infant's condition/complications or the hospital Discharge Summary. After second level care, payment is allowed for the third level of NICU care while the neonate/infant is considered to be critically ill. Once an infant is no longer considered to be critically ill, NICU care codes may not be used. At that point, subsequent hospital visit codes are to be used, even if the infant is still housed in the NICU.

Also, only one physician may bill NICU codes for a single client; therefore, if visits are made by a second or consulting physician to the Neonatal Intensive Care Unit, CPT Evaluation and Management hospital visit codes must be billed by the consulting physician. The Consultation Report and Hospital Discharge Summary must be attached to the claim.

The CPT identifies procedures/services which are considered to be included in the NICU visits. Separate charges should not be submitted for procedures including but not limited to endotracheal intubation, lumbar puncture, vascular punctures, blood gas interpretations, ventilation, surfactant administration, etc. Refer to the CPT for the complete listing of procedures/services which are included in payment for NICU codes and may not be billed separately.

NOTE: A physician's attendance at a Cesarean section or **high risk** vaginal delivery (code 99440 or 99436) may be billed separately.